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frontispiece

PAINTING by Mukumda Kieshner, age 13, Nepal.

Art, a true international language, can be as expressive among children as adults, as this happy painting of home and parents by a 13-year-old Nepalese child suggests. It is one of the pictures from 100 countries, painted by children from 3 to 17 years of age, shown in an international exhibit of children's pictures which had its world premiere in New York last summer. Previews of some of them had been held in Philadelphia and Washington in 1953 and 1954.

Gathered together by D. Roy Miller of Philadelphia through the countries' ministries of education, the exhibit will be made available in whole or in part to communities throughout the world if sponsorship for carrying it as a permanent mobile exhibit can be found. Purpose of the project, in the words of its creator, is to help "build liveable world understanding among children."

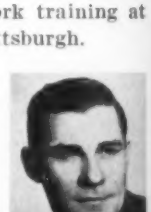
the authors

A psychiatrist, who has specialized in child psychiatry, Dr. Warren T. Vaughan joined the staff of the Harvard University School of Public Health in 1948. He was one of the original team at the school's Wellesley project—a community venture in the development of mental-health practice. In his State position, assumed in 1952, he has found a broad opportunity to continue this interest.

Bertram M. Beck, psychiatric social worker and community organizer, directed the Children's Bureau's Special Juvenile Delinquency Project from its beginnings in 1952 until its termination last July. In his present position he will play an important role in helping to launch and steer the new overall organization of social workers, created through the merger of seven professional associations.

"A pediatrician going into maternal and child health and crippled children's work rapidly becomes interested in the 'care and feeding of communities,' and sees interagency communication as a nurture method," says Dr. Pauline Stitt in explanation of her article herein. In the years between her private practice and current university appointment she has been a regional medical director for the Children's Bureau, director of MCH and CC services in Hawaii, and assistant director of the Alameda County Health Department, California.

Constance Impallaria Albee (who added the third part to her name last summer) has traditionally carried her groupwork practice to "untraditional settings." Before beginning her hospital demonstration for the School of Applied Social Sciences, Western Reserve University, she served as group worker on the staff of the Pittsburgh Child Guidance Clinic. She received her social-work training at the School of Social Work, University of Pittsburgh.



Before joining the staff of the Child Welfare League of America, Joseph H. Reid was research director and administrative assistant at the Ryther Child Center at Seattle, Wash. Still concerned over the problems and possibilities of this type of institution, he recently completed a nationwide survey of residential treatment centers with Helen R. Hagan of the League's staff. Mr. Reid received his graduate training at the University of Washington.

Next month Dr. Frank Falkner will come to this country to become assistant professor of pediatrics at the University of Louisville, while continuing to serve as the coordinator of growth studies for the Centre International de l'Enfance. Since finishing his pediatric training in Cincinnati, after basic medical training in London, Dr. Falkner has been lecturer in child health and research assistant at the Institute of Child Health, University of London.

MENTAL HEALTH FOR SCHOOL CHILDREN

WARREN T. VAUGHAN, JR., M. D.

Director, Division of Mental Hygiene, Massachusetts Department of Mental Health, and Assistant Professor of Mental Health, Harvard University School of Public Health

A SCHOOL mental-health program must be concerned with the individual emotional and physical well-being of all the children and adults making up the school community. Its concern then, from an operational point of view, is not only with specific individuals but with *all* of the human relations and other practices which, in fact, may foster individual mental health. This means that practice of mental health is everybody's business and not the prerogative of specialists in clinical psychiatry. In the school situation, teachers, administrators, nurses, custodians, and school children practice mental health and are on the "mental-health team" no matter how informal the team may be, or how formalized it becomes through the introduction of seminars, human relations classes, and so forth.

In Massachusetts, the Division of Mental Hygiene, as part of a statewide program for mental health for school children, is developing area mental-health centers. These work closely with the public schools in programs of mental-health promotion, mental-health consultation, and mental-health screening. The specific function of diagnosis and treatment is kept in the mental-health center to which the schools refer particular children and their parents.

Public health is concerned with communities, groups of people. Therefore, our program includes a broad promotional program aimed at giving community groups general and specific knowledge about human relations and mental health. For this we employ health-education techniques including the use both of mass media and of small group discussions among teachers and parents.

The second and most important part of our school mental-health program is what we refer to as specific prevention of emotional disorders through the use of mental-health consultation. This represents a systematic development of consultation relationships with key individuals in social systems concerned with growing children. These key persons are encouraged to call upon our mental-health consultants for help in dealing with problems of children. Crisis-oriented, the consultation is concerned first with the key person and his effective playing of his role vis-a-vis the child and, secondly, with the clinical appraisal of the child or children involved.

The consultation work is carried on primarily in public-school settings with the classroom teacher as the consultee, but services are also being developed in other community settings, such as courts and probation offices, public and private social agencies and public-health units. The consultant is concerned with children who are maladapted to the social environment, who are reacting to stresses, and who may be further decompensated if relief of tension in their interpersonal relations is not forthcoming. Currently the Division has 23 psychiatrists, psycholo-

States and communities have various viewpoints, reflected in policy and practice, on where the responsibility lies or should lie for providing mental health protection to school-age children and what it should involve. Massachusetts is one which sees the problem through the broadly focused lens of a public-health viewpoint and is developing a statewide program accordingly. How and why are herein described.

gists, and social workers serving as mental-health consultants on its staff, working out of its 15 area mental-health centers.

Early Diagnosis

The third part of the school mental-health program involves the public-health concept of case finding and early diagnosis. Here the consultant helps the school system to use its own resources in association with those of the community to bring children in need of psychotherapy into therapy programs. The people involved in school-adjustment problems include the parents, the teacher, the school administrators, special school personnel—school nurse, school psychologist, guidance counselors, visiting teachers, attendance officers—and persons representing outside community resources—the family physician, the child-guidance clinic, the family agency, and the like.

Clinical experience shows that many children unable to cope with the demands of the school because of their abnormal ego development end up after several school years with seriously distorted self-images and inferiority feelings. Displacements of hostility, with the habitual use of the school setting to act out against authority and gratify punishment needs, is not an uncommon finding in children's psychiatric clinics.

In Massachusetts in 1951 the average age of children referred to psychiatric clinics was 10. Nevertheless most of them had had long histories of serious emotional disorder stemming from ruptures in human relations in the family or treatment from pathological parents. The school experiences of these children had often served only to complicate their emotional difficulties.

During the first year of operation of the clinical program of the Harvard School of Public Health field program in Wellesley, Mass., the average age of the children referred was also 10 years old. A mental-health consultation program was begun in the public-school system after the first year. By the third year the average age of the child coming into the clinic had dropped from 10 to 6.9 years. The consultation service enabled the clinical service to provide *early* diagnosis and *prompt* treatment.

When the Wellesley demonstration project first began, teachers tended to call on the mental-health consultant only for help in dealing with seriously disturbed children. Gradually, however, as the teachers learned how to use the consultant and as the consultant learned more about the school system, the percentage of children talked about in their interviews who were in need of clinic care dropped to less than 20 percent.

The mental-health consultants are most interested in the primary grades and kindergartens where children are making their initial adjustments to the extrafamilial school setting, where the "unfinished emotional business" of early childhood can be most clearly seen, where the teacher first becomes a key figure in the child's life, and where the teacher and the peer group can be of great help to the child in his emotional growth and development. In these early grades, the consultant, playing his public-health role as case finder, can define psychiatric problems early and bring them to proper resources for definitive study and treatment.

Community Differences

A properly developed mental-health program should help the school in carrying out its functions of giving children a good education in preparation for their life's work and training them for good citizenship. The mental-health service has to be discriminating, however, when dealing with particular communities, since types of organizational and mental-health problems differ from community to community.

In Massachusetts we are working with public-school systems in rural communities, in industrial one-industry towns, in industrial diversified-industry towns, in large cities, and in newly developed suburban communities. The interests and expectations of each community differ in regard to its schools, thus posing different problems for each superintendent. Each superintendent and supervisor differs from the other in his orientation to "mental health." Each school differs in "emotional environment," which is largely determined by the personality, experience, and training of the principal of the school as well as the relationship between the principal and the superintendent of the school system.

Moreover, every school system has a different student-health program, with different degrees of interest and participation by school physicians. Some school systems have nurses working for the board of health while others have their school nursing under the jurisdiction of the school board. This makes considerable difference with respect to how the nurse might function in specific problem situations.

In some communities the teachers are able to enjoy

important feelings of achievement because they are able to give the children satisfactions which they lack in their homes. In other communities the teachers feel, with some justification, that they are deprofessionalized and are considered by the parents only one stage higher in social status than nursemaids or governesses. Some school systems have very active, well-developed parent-teacher associations; others regard such organizations with suspicion, refusing to allow them to develop. In some systems teacher status is based on skill and experience, age and length of service, while in others it is based on the grade taught.

These and many other individual characteristics of school systems become important to the school mental-health worker in his efforts to understand the socio-cultural and economic situations as they influence the emotional growth and development of children.

Other Problems

As the mental-health worker begins to interact with the school system, he is faced with many technical problems. One may be the manner in which he is viewed by individual members of the school system. Because he is an "outsider" and not an integral part of the school system, he automatically arouses whatever anxieties may be present in the educator, those arising from personal roots as well as those "institutional anxieties" common within school systems.

The consultant learns very soon always to go to the principal's office when visiting an elementary school. If this call is neglected, anxieties may be aroused in both teacher and principal. In one elementary school where the consultation service was begun by visits to the principal's office, biweekly visits to the school continued for one year before the principal felt secure enough to allow the consultant to meet with the teachers. In another school, the principal farmed the consultant out to various teachers, never feeling free to use him herself until after a parent-teachers meeting where she was reassured of the parents' approval of the periodic presence of the "outsider" in the school building.

The problem of role definition is always before the mental-health consultant. Although his role is to help the teachers' understanding of specific matters pertaining to emotional growth and development, other roles may be ascribed to him—roles properly belonging to the supervisor because they involve judgment and evaluation of the teachers' educational practices. Often the consultant is viewed as someone who will take a problem off the hands of a teacher. He properly avoids the role of social manipulator and does not allow the school administrators to release to him any of the authorities or responsibilities which rightfully belong to the administrator.

Often the school personnel will assume that the consultant will aline himself with one or another school faction. This most commonly occurs in a school where teachers espousing traditional techniques in education are working alongside teachers who are trained in "progressive methods." The mental-health consultant has to use great care and tact in avoiding identification of mental health with either of these schools of educational practice. Children need to develop self-discipline and need to have limits set by adult authority whether in a class taught by progressive or traditional methods.

Frequently the teachers in a school building who first use the consultant are those with personal needs. They sometimes represent a splinter group or faction in the school. This requires the consultant to work carefully with the principal and elementary supervisor from the start in order to avoid having the mental-health program become identified with any particular faction.

Group techniques are often advocated by school authorities as the most efficient way for consultants to meet with teachers. However, group meetings in school systems often look not unlike the classroom situation, with the principal or superintendent playing the role of teacher, and the teachers the role of pupils. If the consultant operates in this way, he is apt to be assigned those roles and value orientations which the teacher group assigns to the administrator. This may affect his consultation with individual teachers, making it impossible for him to deal with the natural conflicts and feelings the teacher may have with respect to administration. Special studies of this problem have been made in the greater Boston area by Dr. Leo Berman [1] through the use of group dynamics. We have used teacher group meetings in our programs very sparingly, although we encourage and participate in the development of credit courses for teachers in the fields of child development and mental health.

In the Community

The school setting represents only one facet of a particular child's life. The home is, of course, central, and is supplemented by the neighborhood and other important community institutions, such as the

church and various formal social groups including boys' clubs, Boy and Girl Scouts, Y. M. C. A.'s and the like.

School mental-health problems are actually community mental-health problems. Since a school-health program is concerned with the intimate interactions of various community groups which impinge on the life of the growing child, it can be only one part of a total community mental-health program.

In Massachusetts community mental-health associations have been developed to work along with the professional teams of each of our area mental-health centers. The associations not only give tangible support and direction to the professional operations of the mental-health center, but also assume the important tasks of considering, reviewing, and defining various community mental-health issues and developing action programs for solving them. Their functions are much broader than those of the boards of private child-guidance clinics. They are concerned with every issue which conceivably might influence the mental health of families and children in the community. While they are voluntary organizations, they work on a partnership basis with the State Department of Mental Health in each community.

The State of New York, through its recent legislation, is developing public mental-health boards which carry out functions similar to those of the private associations, as well as some of the functions of the Department of Mental Health in Massachusetts. The medical profession plays a key role in both the Massachusetts and New York plans. In New York, the law requires that the medical profession be heavily represented on each public mental-health board. In Massachusetts the State Department of Mental Health seeks representative medical group approval at every phase in the development of the mental-health program. The medical profession participates in the professional advisory committee of the mental-health association.

Division of Function

The public-school system is a relatively new social institution, grown in the past hundred years into an institutionalized representation of the democratic ideals which are our American heritage. As such it is an important culture bearer, symbolizing what is good, desirable, and essential to our way of life. Its schools are expected by the community to impart those sets of values which the community views as important, whether this is good citizenship or flag waving. The current slogan, "Good schools make good communities," is perhaps more realistic when reversed to read, "Good communities make good schools." While socioeconomic factors and personnel shortages also come into the picture the set of values which is found in a school system, from the pupils and teachers to the administrators and the school board, represents a fair approximation of the values and standards of a community.

Children begin school differing greatly in their readiness for the learning process and for mixing with persons outside their own families. Current knowledge in the field of child development and mental health clearly points to the fact that behavior and achievement of children in school are related within limits of constitutional endowment to: (a) interpersonal relations and emotionally relevant experiences in the child's early preschool life; (b) current emotional crises in the child's family or neighborhood life; and (c) unique personal meanings of the school experience to the child.

This means that the performance of the child in both the social and academic spheres is symptomatic of his mental health and can be understood only in terms of the emotional growth and development of the individual child studied longitudinally in the context of his emotionally relevant human environment. Undesirable performance and behavior on the part of a child must be understood before rational approaches for meeting the problem can be devised.

Mental-hygiene concepts, such as "growth and development" and "emotional maturity," can be introduced into the everyday work of the school personnel—teachers, principals, nurses, guidance people—but they should not be allowed to obscure the key function of the school to develop those sets of values and standards of behavior which the community desires to have in its children. A teacher may have insight and understanding regarding a child's behavior without condoning or tolerating the behavior. The classroom is a classroom in a public community setting. It is not the place for private group therapy. The teacher has many functions but psychotherapy is not one of them.

Psychiatric-treatment functions cannot be properly carried out in school settings, especially since the symptoms which manifest themselves in the school are expressed through clashes with the value system. In many school systems the guidance director is quickly viewed by most teen-agers as the person who "sees the bad boys," although he may have spent years interpreting his function to his

colleagues, trying to keep disciplinary problems in the administrator's office and out of his.

The parent who makes a school visit, especially in the lower grades, anxiously asks the teacher "Is my child behaving properly?" or "Is my child doing well in school?" These are proper parental concerns. In fact, their absence in a parent may be symptomatic of some disturbance in understanding or feeling. The interview with a parent in a school setting is completely different from the interview with a parent in a private medical setting, although his underlying concerns may be the same. This is due not to differences in quality of personnel but to the inherent fact that the value-oriented school setting, in which judgments are, quite properly, being made, is not an appropriate one for individual psychiatric investigation.

People reveal, in fact are expected to reveal, private matters in the nonjudgmental medical setting. A child may properly "undress" himself in the clinic. It is inappropriate and symptomatic of disturbance for him to do so in school. He should not be encouraged in such behavior by the school personnel, be it educational, guidance, or health. Guidance personnel are concerned with the ego development and the life adjustment of children in relation to their current and future educational and vocational enterprises, and so, with *how* children are dressed, inasmuch as clothes represent the ego development. They have techniques of interviewing similar to those used in the psychiatric clinics. They may also have the same knowledge as the clinician concerning the instinctual life, or deep motivation. However, in the school setting this knowledge should be put to use in the area of ego strengthening and development, not psychotherapy.

In the area mental-health centers in Massachusetts we encourage the participation of the parents, the family physician, and various community resources, in particular the center's own clinical facilities, in the actual job of problem solving and treatment of children attending public schools. This gives us the opportunity to clarify for the community and ourselves the proper mental-health functions of medical services on the one hand and educational institutions on the other.

The three phases of mental-health programing in Massachusetts—promotion, consultation, and early case finding and clinical treatment—are completely dependent upon each other for their proper development.

Thus our mental-health program begins to look like a true public-health enterprise, interested in the emotional growth and development of *all* the children in the school system. We begin to make some progress away from the idea that mental-health programs offer nothing but psychiatric treatment for sick children.

Research Needed

It is too early to speak of evaluation. We do not yet have techniques for measuring the "mental health" of a school or a community, necessary for purposes of comparison 10 or 15 years hence. Hence we are dependent upon impressionistic statements from school authorities, such as "the mental-health consultant has been very helpful to us this year." We are in great need of basic research using public-health and social-science techniques. The work is also handicapped by a tremendous shortage of trained personnel for mental-health work and almost no facilities in the country for training in community mental-health practice.

There is always a lag between knowledge and the development of specific programs to apply the knowledge. Today, however, a sound body of fact and theory is available from the fields of child psychiatry, social psychology, anthropology, pediatrics, and education which can form the basis for sound school mental-health programs. It only awaits the passage of time, as the understanding of the nature of such programs becomes more general and trained professional workers become more plentiful, before such programs will begin to make their contributions towards the development of mature, healthy members of our American society.

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[1] Berman, Leo: Mental hygiene for educators; report on an experiment using combined seminar and group-psychotherapy approach. Psychoanalytic Review 40: 319–332 October 1953.

Conflicts in modern cultural values have played a major role in producing . . .

THE EXILED DELINQUENT

BERTRAM M. BECK, M. A.
Associate Executive Secretary, National Association of Social Workers

SEGREGATION OF GROUPS of people from the rest of society plays a major role in the production of delinquency and criminal behavior, as well as in its perpetuation, despite the best efforts of persons and organizations concerned with the rehabilitative processes. Desegregation is *the* treatment indicated for large numbers of convicted offenders and adjudicated delinquents.

There is one common denominator among all persons in conflict with the law—that society has found them to have used socially unacceptable means to achieve ends that may or may not be socially acceptable. Since our society is so productive of both crime and delinquency we may well ponder why so many youngsters and adults are prone to violate social restrictions.

Robert Merton provides some food for thought in his volume, "Social Theory and Social Structure," [1] in which he points out that, while the goals of our society are highly articulated, the means of reaching those goals are not at all well defined. This contrasts with the patterns of the more primitive cultures described by anthropologists.[2]

In primitive cultures not only is man's goal quite clear but ritualistic custom and strong taboo mark the path for achieving it. Childhood and adulthood are often clearly delimited by initiation rites. Socially sanctioned training is given for vocational function which is group oriented rather than individually oriented. The path toward important phases of life's activities—birth, courtship, marriage, childbearing—is clearly marked as is the process for life's minutiae. Nonindustrial older cultures have means and ends which are equally well articulated.

Such cultures also produce deviants from the norm but their deviation is more likely to be along neurotic rather than delinquent lines. Observers in Iraq, for example, recently reported that, while childhood delinquency is practically unknown there, the incidence of childhood hysterical disorders is high. In other words, when deviant behavior is clearly suppressed and forbidden, family and culture conspire to develop a strong super-ego in the individual, who drives his hostile impulses inward rather than taking them out on the community.

Goals and Means

Popular magazines, television, and other mass media create and portray our cultural goals. They are clearly related to being young, beautiful, sweet-smelling, rich, powerful, loved, and admired. Not so clearly defined are the means of achievement. Ostensibly our way is guided by the Judaic-Christian teaching—"Do unto others as you would have them do unto you"—but this is often left for the Sabbath only. In real life the stress is on aggressive, individualistic competition. The prize is to the one who arrives. If he has taken a short cut to get there, that isn't too important. Social nonconformity grows where there is a marked disparity between verbally sanctioned means and those that are really acceptable.

The task of growing up in America is further complicated by the fact that we have quite properly developed values consistent with the democratic process. We hold for individuality, nonconformity, vertical progression through class lines, and equality of opportunity. Here again, however, a marked difference often exists between articulated values and real life. One need not look far to perceive areas wherein individuality and nonconformity are penalized, vertical progress limited, and equality of opportunity denied.

Growing up in the democratic society *must* be

Based on a paper presented at the 1955 Forum of the National Conference of Social Work.

difficult since the premium is on finding one's own identity rather than on having identity defined by society. The end result is a more expanding culture than that which is produced by standardization. The difficulties are enhanced, however, when there is a pronounced difference between preaching and practice. How are family and community to transmit culturally accepted means and ends to the young when there is such uncertainty in defining just what is acceptable?

This culture, like all others, depends upon the family and the community, as manifest in social institutions, to induce conformity to social demands. Because of its paradoxes the family structure and the social institutions of the community must be particularly strong. When they are not, numbers of persons are shut off or segregated from the collective source of group strength and identification and are prone to strike out at the community from which they are isolated. From the ranks of these come many of our delinquents and criminals.

A particularly dramatic effect of basic separation from the source of forces which make for social adjustment can be discerned among infants who are deprived of maternal care during the first years of life. Freud has described the infant as "all id" and the function of loving as laying the foundation for cultural adaptation. Bowlby has amassed evidence which suggests that the absence of a loving teacher in the early years is a primary factor in inducing psychopathic behavior.[3] In other words, deprivation of the satisfaction of instinctual urges during early years so weakens the civilizing process that the individual becomes impulse driven and unable to withstand frustration. As a result he grabs to get what he wants without reference to socially sanctioned means, and so sets himself apart from the social process. This is a type of segregation induced by family failure.

Slum areas, such as this, tend to produce frustration resulting in a subculture with vague or conflicting values. Adjustment may require a child to develop ways unacceptable to society.

Community Failure

Segregation may also be induced by community failure. This is dramatically illustrated by the disproportionate number of criminals and delinquents bred in the city slums. Clifford Shaw's pioneer studies[4] clearly illustrated the manner in which slum environment produces delinquency regardless of the particular ethnic group involved. Slum dwellers are isolated from the larger community by their inability to achieve the socially accepted goals of power and prestige and by their feeling of failure. Often their failure to achieve has been related to their status as members of an unaccepted minority group and consequent aggravation of feelings of rejection. Such multiple frustrations give rise to aggression toward those beneath and above them on the social totem pole.

The child growing up in the slums quickly perceives that the fight to survive is a literal fight. As Allison Davis' studies[5] have indicated, he adapts to the slum community but in a manner unacceptable to society as a whole.

Delinquents and criminals developed by this type of community-induced segregation tend to form what Frank Tannenbaum[6] has defined as a criminal subculture—a group within society which strives toward accepted materialistic goals through unorthodox means. Such groups have their own loyalties and code of behavior. Doing time behind bars comes to be accepted by them as something which happens in the normal course of events.

Bernard Lander's recent study on delinquency in Baltimore[7] indicates that the failure of the slum community to induce social conformity stems from the presence of intergroup conflict which militates against the development of a spirit of togetherness. Using the techniques of factor analysis Dr. Lander shows that the common concomitants of delinquency, such as poor housing and poverty, are not accompanied by crime and delinquency when a collective strength amongst the persons burdened by such problems engenders positive group feelings.

Such findings make it possible to see how suddenly developed middle-class communities, without com-

Restriction of his freedom through forced detention tends to aggravate the young offender's concept of himself as an "outsider" unless the institution is staffed and equipped to rehabilitate through therapy and other creative institutional programs.

munity services or tradition, may be limited in their capacity to induce social conformity. Each family comes to such developments separately, removed from contact with kith and kin, lacking any sense of "togetherness" with their neighbors.

Some individuals experience both family and community "shutout." This is most common in the slums where the same factors that disorganize community life prey upon the tissue of family life. The type of delinquent produced by this kind of segregation is exemplified in the works of Fritz Redl[8]—the slum child who is reared in a succession of foster homes, broken family units, or unbroken but extremely pathological families. Unlike the delinquent whose behavior is induced by community shutout only and manifested in defective superego function, this doubly deprived delinquent usually has severe ego impairment.

On the other hand, many persons are exposed to community segregation but induced to social conformity by enclosure in family units. The slum-bred nondelinquents in the recent Glueck[9] study were deterred from delinquency by the superior quality of their family culture. This imparted a sense of "togetherness" which made them impervious to the influence of the slum community.

Thus, the inducement to antisocial behavior in persons is largely determined by the degree to which their family life or their community life fails to impart a sense of togetherness. There are, of course, also instances of crime and delinquency produced as a symptomatic expression of a neurosis. Social work's error in the past has been to consider these relatively few instances as the whole and to assume that all delinquents could be treated without reference to their isolation from the aspirations and ethics of the larger society.

The major role social disorganization plays in the production of crime and delinquency is clearly revealed by the fact that the present increase in delinquency is accompanied by an equivalent increase in adult criminality. Unless we are to view this relationship as fortuitous, we must look for causative factors affecting both adults and juveniles and so must raise our sights beyond parents, schools, or comic books. This forces us to the unpleasant conclusion that social disorganization is on the increase; that we are failing to bring increasing numbers of both children and adults into the large scheme of social values. Unable to find a source of strength in a collective sense of purpose and dedication many individuals cannot attach themselves to the social whole and, like meteors which crash through emptiness, finally end in collision.

Formalized Separateness

Whatever differences exist amongst those who break the law, a "secondary homogeneity" is induced once these individuals are brought before the bar of justice.[10] The neurotic and the end products of family and social segregation, all are marked as offenders against society. The very separateness that leads to their antisocial behavior is formalized. No matter what the intent of treatment, the offender views the experience in simple terms of punishment for wrongdoing. Free-floating guilt arising from long-forgotten deeds or buried wishes becomes attached to the immediate circumstances. Without therapeutic intervention, this guilt induces anxiety which is dispelled by acts of hostility. Society's action, therefore, in bringing the offender to justice, more often than not fixes his concept of himself as segregated and adds psychological fuel to the fire.

The consequence of a finding of guilt—and to the youngster concerned an adjudication of delinquency is the psychological equivalent of a finding of guilt—is invariably a restriction of freedom. In a culture which places high value on individual freedom this

action accentuates the apartness of the convicted—the greater the restriction, the greater the segregation. Probation involves some restriction but institutional commitment is the final and dramatic act of segregation, placing the offender in a community of offenders set apart from "good citizens." The social structure built up by the institutionalized is often continued after their freedom is restored. Thus society's mechanisms for protection actually become mechanisms for the production of criminal and delinquent subcultures.

Courts and Institutions

Much of this would not come to pass if the institutions for dispensing justice were capable of dealing with the problems brought to their doors as well as with the problems they themselves produced. In the first place, court function should be limited to situations in which the unique contribution of the law is required. Communities which maintain the juvenile court as the door to child-welfare services and make adjudication the price of service unnecessarily impose the stamp of segregation on many children and their families. Moreover, police officers more interested in running up records of arrest than in exercising the discretion legitimately theirs would sometimes serve the community better by an act of omission. In times such as these, when interest in delinquency borders on the hysterical, it is well to remember that some aggressive behavior is normal and that the best course of action in dealing with it is sometimes none.

When individuals do come before juvenile or criminal court, they should have fair hearings with due process of law for adults and appropriate safeguards for the civil rights of children and their parents. Too often frank corruption of justice or short cuts taken for administrative reasons reinforce the troubled person's concept of the larger society as hostile and unfair. We social workers can see this easily as far as adults are concerned, but we often miss it in regard to juvenile and young offenders. Our vision becomes obscured by the trappings of treatment meaningful to us but not to the offender.

For the adjudicated offender the properly trained probation officer has a rare opportunity to be of service. Since the probation officer is vested with the formal legal authority of the court and his services are usually offered to an unwilling client, there is often created a microcosm of the latter's struggle against social authority. By transforming formal authority into what Elliot Studt [11] has termed "psychological authority," the probation officer can help the client to mobilize his strengths to make full use of the testing period allowed by the court and to see his rebellion against authority and the self-destructive ends it serves. The probation officer's personal acceptance of authority as a positive quality and his treatment of the offender helps those who have been shut out by the community to revise their own concept of authority. The client's dependency on the probation officer's authority recapitulates a parent-child relationship and so offers opportunities for offenders who have experienced family shutout to perceive interrelationships and act upon that perception.

In a similar fashion an institution which is based on belief in an individual's capacity to grow, can prepare those it segregates for reunion with the larger society. By maintaining a permissive atmosphere it can crack the shell of the offender who expects retaliatory punishment and is ready to give as good as he gets. When his expectations are not fulfilled, vulnerability to change is created. If the institution has a rich and varied program it can then provide opportunities for the offender to develop his potentials and to test the new reality coming into focus.

Correctional facilities staffed and equipped to rehabilitate persons rather than to create new problems are all too rare. This is despite the fact that it is far less expensive to rehabilitate than to provide for longtime penal care. Similarly the qualified probation officer can serve selected individuals in their own homes at one-third the cost of the institution—and more effectively. Nevertheless, there are States with practically no probation service. In every State some persons are committed to correctional institutions merely because there is no probation officer to supervise them in their own communities.

Society's Rejection

Why in a society with both Judaic-Christian and materialistic values is it so difficult to find support for social provisions which are both godly and economical? Plainly, because some fundamental resistance is encountered. The real nature of this resistance is revealed when we compare the enormous public appetite for stories of crime and delinquency with the persistent public desire to punish the criminal and delinquent.

None of us is totally immune to the social forces which produce the criminal and the delinquent. The same forces that lead to overt criminality make it difficult for many of us who are not behind bars to handle our aggressive, destructive impulses. Our

dim recognition of these impulses propels us toward the delinquent or the criminal with consuming curiosity, but at the same time repels so that we must hate and punish the offender. We cannot forgive him because we cannot forgive ourselves. We cannot let him "get away with it" lest our own hostile impulses get away with us. The criminal and the delinquent serve a tragic social function as scapegoats for the fancied sins of "good citizens." Thus, the segregation within the family, the segregation within the community, and segregation by the correctional processes are compounded and overlaid by the segregation of public wrath.

Social workers are not immune to the factors that produce the public's reaction of rejection, but their influence has a more subtle manifestation in our professional life. We, too, have exiled the delinquent and the criminal by our overall lack of interest in the field of corrections; by maintaining services chiefly for groups that have no room for the aggressive, the hostile, and the obstreperous; and by closing access to casework skill to the heavily burdened, downtrodden, and disenchanted poor and opening it to the middle-class neurotic whose suffering is similar to our own and whose aggression, like our own, is displayed in symbols rather than in open hostility. There is still a long way to go in spreading our recently awakened interest in the hard-to-reach.

When one talks either to social workers or the general public about crime and delinquency the interest soon shifts from the offender to prevention. It is much easier to consider health and welfare services for a deprived 7-year-old than to come to grips with the hostility of a 19-year-old thug. However, prevention cannot be achieved by the small potatoes of tiny additions to this or that therapeutic service, but only by that social and spiritual reformation that will bring our real values into accord with our verbalized values. Without that major reformation we can have neither prevention nor treatment since a community that is oriented to dog-eat-dog competition does not care enough to support the requisite programs, services, and facilities in the necessary quantity or the necessary quality.

When we encourage or allow the focus of community concern to shift from the hard fact of the delinquent and the criminal to the illusion of prevention, we provide the community with an easy out. The basic problem is nowhere more sharply focused than in the community's handling of the offender. If the cry that has come down through the centuries, "Father, forgive them for they know not what they do," has significance in our age, why must we punish and brutalize the offender? If we are our brother's keeper, why do we exile him?

If we cannot deal constructively with open hostility directed toward us in our own community, how are we to deal with our own hidden hostilities or the hostility directed toward us as a nation? To the extent that we can help the community in facing up to the problem of the delinquent, we shall be successful in creating a community in which basic religious and democratic values are both theory and practice. This is the community that cares and through caring meets its collective needs and is cared for and thus establishes a bridge between the individual and his society.

The task is enormous and the danger of failure great. The issue is not just *punishment vs. treatment* for offenders; but *love vs. hate* in our society. If hate triumphs and we can only meet hostility with hostility, then our day is lost indeed. If, however, we can face hostility and act, not out of our own hostility, but out of a perception of the needs of those who aggress against us, we shall not only bring the delinquent out of exile, but we shall move forward toward a world in which men can live in peace and harmony with one another.

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Ways of handling interagency communication depend on . . .

WHO WANTS TO KNOW?

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INTERAGENCY COMMUNICATION consumes great blocks of time in any health or welfare agency. The time is often given grudgingly and the whole process regarded as a nuisance. Yet this task has possibilities of being of benefit to the agencies themselves and to the people they serve. The process can be stimulating and invigorating instead of a chore or a bore. Making it so depends on tailor-fitting the reply to meet the needs of the recipient. How this is done depends to a considerable extent on *who wants to know.*

When information is exchanged effectively between agencies, a number of benefits result: *primary* benefits or "products," and *secondary* benefits, or "byproducts."

Primary Benefits

The *primary benefits* are the direct results: the immediate benefit to the individual on whose behalf the information has been sought; the benefit to those who help the patient; the joint thinking in behalf of the child.

The immediate benefit to the child is, of course, the major concern, but its achievement often comes through *helping those who help the patient* in a sort of relay fashion. At any given time one agency or one worker may stand at the point where the program meets the patient, while the rest of us take our place as in a bucket brigade, busily passing along materials to help the one who is closest to the problem.

One of the ways we do this is through the *selective* reporting of information. This kind of reporting gives information functional value. It reports data chosen on the basis of its usefulness to the inquirer and its applicability to the situation for which it is requested. It involves *who* wants to know, plus *what* they want to know, and *when*, *where*, *how*, and *why* they are planning to use it.

Who wants to know? is the key question. Its answer opens the door to other vital questions, such as: What is the actual situation for which this information is sought? or what sort of information might be most helpful?

By considering *who wants to know* we can establish and appreciate a frame of reference for our report. The information might be intended for a schoolteacher, a plastic surgeon, a group worker in a summer camp, or someone else whose special skills touch the child's life. In each instance the type of inquirer and the nature of his needs would influence the selection of material.

There would be certain common denominators of information which all inquirers would want and need—for instance, items of general information, identifying data, and other facts which might convey an overall picture of the child and his environment. In addition, each person seeking information would need special types of data, desirable, or even indispensable to carrying out his particular kind of service.

As for giving the patient the *benefits of joint thinking*: in the thoughtful exchange of information, more is involved than simple reporting. The informational exchange is not a mechanical transaction like the operation of a public scale which presents a man with a card containing a statement of his weight.

It is, rather, a collaboration involving those who give and those who receive the report.

There are three critical points at which this collaboration is actually accomplished: when the request is *made*; when the request is *received*; and when the request is *filled*.

When the request is made the inquirer can help by indicating how he intends to use the information. Take the following request:

"We understand that Herbert is known to you because of a slipped epiphysis of the right hip. Will you please give us a report of your findings in this case?" This is going to produce a different reply than if it were worded thusly:

"We need some medical information to guide us in planning for Herbert Jones. At present we are attempting to arrange a boarding-home placement for him. One possible placement involves a three-block walk to school; the other involves about twice that much walking to get there. We would appreciate some help in knowing just what Herbert is able to do and whether any special precautions are required. Are there any restrictions on the amount of walking he should do? Should he avoid all sports or are there certain ones in which he might safely participate? In one of the proposed homes the other children participate in the housekeeping activities. Would it be all right for Herbert to do this, and if so, are there any precautions which he should observe?"

When the request is received, the recipient himself has an opportunity to inquire: "What sort of information would be most helpful to you people?" Such a question often comes as a refreshing surprise.

In filling the request the person scanning the available data can select the cream of the material—"cream" in the sense of its special helpfulness to the person who will be using it for the child's benefit. A report so assembled might say something like the following:

"We are sending you the enclosed information about Rudi Oroco. We believe that Rudi's teacher would find it helpful to know that as a result of the numerous ear infections he has had in the past year, he has a moderate loss of hearing in the speech range and should sit well toward the front of the room. The school nurse will want to know that his ear condition is at present under the care of the otologist, Dr. Jefferson, a summary of whose findings and recommendations is enclosed. You will note that Rudi's hearing is to be retested in January."

When reporting involves such collaboration between givers and receivers, the child gets the benefit of what sometimes amounts to a miniature case conference. Under such circumstances, reporting is not a static rendering of a statement of the status quo, but a dynamic way of moving the child's care forward.

Secondary Benefits

The *secondary benefits*, or byproducts, include:

1. ***Indirect benefits to other patients or clients.*** It is axiomatic that every well-cared-for patient or client tends to enhance an agency's quality of care. The achievement sets new standards. Moreover, the activities that go into providing that high quality care establish new insights and set up new operating methods. Each individual working on the case acquires a bit of new competence, and at the same time, the agency itself gets a new vigor in the form of improved administrative methods.

2. ***Improved administrative methods*** bring about more effective use of existing resources—funds, facilities and personnel—for functional reporting results in functional development of policy and procedure. Good reporting actually stimulates the clarification of policy. Many agencies find that almost every report they issue produces at some point the comment, "Oh! Is *that* your policy?" Somewhat like Moliere's character who was astonished to learn that all of his life he "had been speaking prose," the reporting agency realizes for the first time, that it actually does have a policy on the subject; that the conduct of the specific case is not just an isolated situation, but actually an expression and application of agency policy which perhaps never previously had been articulated or even formulated.

An agency can be on the alert for these spontaneous expressions of policy, and the procedural methods improvised to execute them. Recognized as "newborn" policy and procedure, and not lightly dismissed as isolated, unrelated "decisions," they can be recorded, adopted, and put into official use. Policies and procedures produced in such a fashion have vigor, life, and relevance.

Functional reporting is also apt to bring about increased interdisciplinary communication within the agency. As soon as an agency attempts to render tailor-made, custom-built reports, designed to be of maximum helpfulness in terms of *who wants to know* the recipient of an inquiry tends to clear with other staff members on certain aspects of the information to be given out. The resultant collaboration not only produces a better balanced, more valuable report, but

has a strengthening, unifying action on the agency's staff. "Teamwork" becomes more than an empty word and is now a real collaboration and interaction.

3. *Improvement of resources.* Improvement of resources proceeds through three main channels: staff development; interagency development; and community development. While improved administrative methods bring about a better use of resources, staff development and community development improve and even create the resources themselves.

The improved communication within an agency, and the actual give and take with the outside world, offer new dimensions to the individual staff members. They provide a tangible way for agencies and the various professional disciplines to join forces for productive use of one another's talents. The process engenders respect—for the child as an individual, and for the unique ability and contributions of each agency and individual serving him. In such collaboration, each professional person brings his own special talents to bear on the child's problem and simultaneously learns more and more about what others have to offer him. As a result the participants gradually become better in their own lines. Learning each other's viewpoints, they become richer and better endowed in the valid individuality of their own special professions and agencies.

The desire for interagency cooperation is easy to express, but the actual cooperation is difficult to achieve and requires every implementation possible. Sound methods for the exchange of information offer workable tools which quietly and almost automatically get some degree of mutual working relationships under way between agencies. The value of this can scarcely be overestimated.

Two methods for achieving interagency and community development include program interpretation and health education. Functional reporting can strengthen both.

Good reporting interprets policy as well as stimulating its formulation. It also interprets programs and agencies. Every report that an agency issues interprets that agency to the community. While the inept report may give little or no information about a patient, it speaks eloquently about the weaknesses of the agency sending it. A helpful, well-thought-out, clearly stated report presents between its lines a vivid picture of the agency that prepared it.

An example of functional reporting strengthening health education might occur in a maternal and child health agency's collaboration with a welfare agency in the care of an unmarried mother threatened with toxemia. Given a clear interpretation of the meaning of the girl's condition, the welfare agency would be blessed with new insights as to the importance of prenatal care, the particular significance of prenatal diet, and the urgent nature of toxemia and eclampsia. A health department rendering adequate reporting in such a case might achieve more meaningful and lasting health education on prenatal care by this means than by formal education sessions for the welfare staff.

The central role of an official agency is community leadership. An enlightened leadership harnesses the finite means which the community offers to attack the infinite problems which the community presents. The weapons—funds, facilities, and personnel—are seldom confined to any single agency, but are scattered about not only through other agencies, but through the whole community. In its leadership role the agency must develop methods of communication which effectively utilize and strengthen those community potentials.

A Case Report

Let's see how, instead of a perfunctory response with an assemblage of miscellaneous data about a patient, a case report can be a thoughtful presentation of selected features, relevant to the situation for which the information is sought:

An agency serving crippled children received a request from a school for information regarding a child with cleft lip and palate. The query came by letter from the school principal's office, and asked for information about Dinah Rinehart, a 9-year-old girl who had just come to the school from a different section of the city. It stated that the school personnel understood that Dinah had been under the care of the crippled children's agency for surgical repair of cleft lip and palate, and would appreciate a "summary of the findings."

The agency took the request literally. Some fatigued staff member laboriously thumbed through a bulky record of its 9 years' acquaintance with Dinah and chronologically enumerated a hodgepodge of medical and social highlights of the little girl's life. These included such matters as the date of the lip repair, the attempts that had been made at palate closure, the dates and place of hospitalization, and reference to a siege of postoperative pneumonia and to repeated ear infections. The report also recorded that Dinah's mother had died when the child was 7 years old and that she had been living with her maternal grandparents ever since. It mentioned that

Dinah was now understood to be repeating the third grade.

When the school personnel received this information, they were just about where they had started. After all, they had Dinah herself with them, and so were not surprised to hear that she had a "repaired lip and an unsuccessfully closed palate." To be sure, they had not known that she had had complications of pneumonia and ear infections along with her other difficulties. But even with the agency's letter in hand, they could not tell whether these past illnesses were of historic interest only or even at this late date might be exerting an adverse effect on her school adjustment. They knew too that her mother had died of some lingering illness 2 years earlier. As for Dinah's school status, they already possessed data on that.

Nevertheless, the school was not displeased with the agency's reply. It was regarded as being as satisfactory as such things usually are. It fulfilled the purpose of "clearing with other agencies." It confirmed impressions which they already had, and it "completed Dinah's file." But it did not help the people who were trying to help Dinah.

Functional Reporting

Fortunately for Dinah, two concerned persons united their professional efforts in her behalf—the school nurse and the nursing consultant from the crippled children's service. One afternoon they got together in the office of the crippled children's agency, and looked through Dinah's old record, with the purpose of making functional summaries in terms of the needs of the people who were trying to help her.

They made one summary for Dinah's teacher, one for the surgeon who was contemplating possible further surgery, one for the school nurse herself, and one for the public-health nurse.

All of the summaries carried the same basic data—chronological highlights of Dinah's nine harassed years—but in addition each was individualized with specific terms of practical meaning to the recipient. For example, all four reports contained speech and hearing information including the findings of repeated audiometric examinations. In the report for the teacher these were briefly summarized but fully interpreted in terms of classroom meaning, such as "seating in the front of the room." The teacher was also given full data on past psychological examinations and some other available material throwing light on personality factors.

The report for the surgeon contained fuller details of early medical experience, including much that was nonsurgical but which would need to be taken into consideration if subsequent surgery were to be of maximum usefulness. For instance, there was a succinct summary of a wealth of pediatric material indicating that Dinah's nutritional status and general condition might need to be improved before she was subjected to any more elective surgery. There was also some important material about her past bleeding and clotting times and hemoglobin levels which had previously caused trouble.

The public-health nurse, through her report, was provided with all of the foregoing data and queried regarding the status of Dinah's grandfather, said to be careless of a positive sputum.

Later on the agency received two more requests for reports about Dinah. In both instances the same basic data were included in the reply, but interpretations were individualized and additional items selected to make the reports genuinely useful to the inquirers—the leader of a summer camp where Dinah was being considered for a "scholarship," and an orthodontist who was making a treatment plan.

The concept of "functional data," as exemplified in these reports on Dinah, was vividly expressed recently by the chief social worker of a child-placing agency working out foster-home placements for children with rheumatic fever. Said she: "We don't want data on sedimentation rates. We want data on tennis games." She explained that sedimentation rates meant little to her agency but that information as to whether a boy might be allowed to play tennis, and if so, what precautions he should take, was highly pertinent to its planning.

A tally of informational exchanges between agencies will usually fall into a pattern revealing that the majority of requests received by any agency tend to come from a few sources. When these are known it would be administratively practical for a representative of the agency and of these sources to get together to work out details concerning the general types of information which they all would find helpful. The general guide thus developed could be used for assembling basic information concerning most of their clients or patients when inquiries are received. Interpretations and additional information in the reports could then be individualized by the workers.

Through such functional reporting the best interests not only of the child involved and of the person trying to help him but also of the requesting and reporting agencies and the community at large would be served.

A Cleveland hospital demonstrates the emotional value of . . .

GROUP WORK WITH HOSPITALIZED CHILDREN

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IN THE PAST 4 YEARS a program of groupwork in the Babies and Children's Hospital in Cleveland has grown from an experimental stage to one characterized by confidence and acceptance. It came about as part of an effort to broaden the focus of the pediatric division and has become an integral part of the division's program.

Anna Freud visited Cleveland in 1950, stressing the effects of sickness and hospitalization upon children. Afterwards, the hospital's child psychiatry outpatient department planned to expand its services to the division of pediatrics. As the hospital achieved a more creative pediatric child-psychiatry program it paid increasing attention to the emotional problems of the hospitalized children. These problems included: the effect of separation from parents and home; feelings about loss of independence, freedom, and privacy; reactions to injections, anesthesia, and other procedures.

This change of focus resulted in a number of outward changes. Daily visiting hours were instituted by the hospital administration. The social-service department assigned caseworkers to each of the wards and in 1951 instituted the groupwork program.

The first groupworker was assigned to the medical ward. She had to learn a great many things about her task. True, the way the groupworker functions within the hospital setting has a basic similarity to his functioning in any agency where groupwork is more traditionally practiced. The goal is still "through some satisfying group experiences to help individuals to develop their social relationships and to help them to deal with the problems presented by their environment and to use the resources of this environment in a constructive way."[1] However, in many aspects a hospital setting is different from others. Usually a group in a traditional groupwork agency is formed because of the members' common desire to participate in a special activity. In a hospital setting this is not the case.

Joining the Group

Joining the group is one of the few things that hospitalized children can choose to do or not to do. However, the experience they share in the hospital is a strong potential for drawing them together. Their fears, anger, and anxieties can be more powerful than a common interest in cooking or woodwork or even closeness in age. The age range of a hospital group is broad, sometimes ranging from 4 to 14 years.

In her efforts to encourage relationships by consciously grouping children or introducing appropriate kinds of program activities, the groupworker makes use of the common bond of illness and of the parental role in which the children cast her. She sometimes places beds and wheelchairs in strategic positions to enhance the children's awareness of one another. Although a child may be in the next bed to another youngster, they may not even begin to relate to one another unless purposeful means are used.

This was true of 10-year-old Pat, who when the group worker first saw him had been on the children's surgical ward for about a week. He had been trans-

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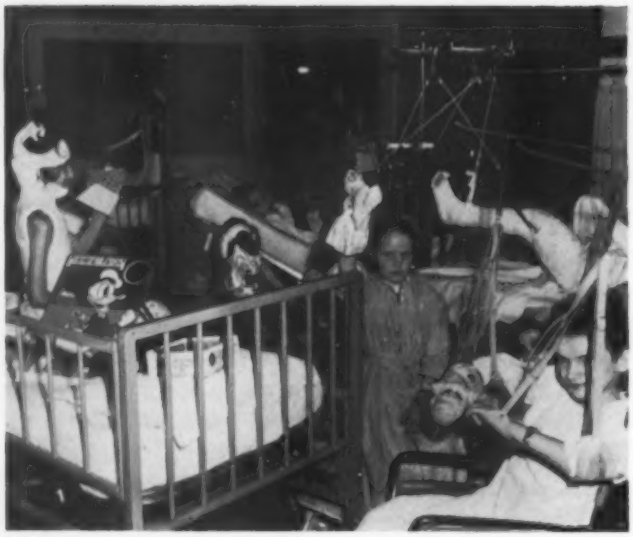


"Props," like the glove-type puppets these children are wearing, can help the hospitalized child escape his environment in the world of creative imagination. Helping immobilized children to play together as normally as possible is one of the social group worker's chief functions on the ward.

ferred from the adult floor where he had been in a respirator following an attack of polio and where he had been the "darling of the ward." He had been moved to the children's ward because his doctor felt that he needed the company of youngsters his own age. However, he still had no contact with children as his parents were constantly hovering over him. He was never interested in doing anything suggested by the groupworker in her bedside rounds before the start of the evening meeting, but preferred to continue playing with his father. He ignored the meeting even when it was held at his end of the ward.

Pat's father, however, became interested in what was going on. Several times he asked the groupworker what this playing and talking "was all about." The group worker told him how helpful this play could be, especially for a child who was afraid and lonely in the hospital. The father said that maybe Pat "wasn't a good customer for the group," but added that perhaps the boy had been with adults too much and needed the company of other children. The groupworker agreed, saying that Pat would be welcome in the group when he wished to come.

The father showed considerable understanding. He began to go out to the waiting room more often for a smoke, leaving Pat with nothing to do but to watch the youngsters at their play. Eventually, with encouragement and support from the groupworker, he began to make occasional comments during the discussions or games. One evening when the worker asked him whether the group could meet by his bedside, Pat looked uncertainly at his father, then back at the worker, and nodded his head. However, there was almost no interaction between Pat and any other child. Several times in the course of the meeting he asked for his father, who would not only come and be with him but also take part in some of the group activities.

As time passed Pat began to relate to the groupworker. When activities such as guessing games were underway he would always direct his questions or answers to the worker, who would serve as his "communicator" with the other children. The rhythm band, an activity which did not require much interaction with the others, became an important way for him to take part in their activities without calling attention to himself.

Because of his paralysis Pat had very little use of his arms, but he learned to fashion some things out of clay and to paint somewhat awkwardly. He always appeared ashamed of what he had done and would crumple up his work and throw it away. The groupworker encouraged him to take as many pieces of paper as he needed to "practice." This individual activity "in," although not "with" the group, was an important step.

Eventually, Pat began his own attempt to be a part of the group, by suggesting games to play, usually those where objects were passed from one child to another—an indication of his need for physical contact with the other children. His father stayed out in the waiting room for longer and longer periods without protest from Pat. The other children began to include *him* in the group. They asked him about his illness when they discussed theirs, and picked him often in the games in which children choose others for a turn. Gradually Pat became a person of fairly high status among them.

Status in a hospital group frequently is determined by the child's length of stay, his age, or his illness. Pat attained his because he was an authority on the various ward procedures. The worker would call on him frequently to "explain" things, and he became a source of great reassurance to the other children. For example, when a medical technician came on the ward to take blood from a child Pat sensed the anxiety and discomfort of the other children. He reassured them by explaining that the process was not as bad as it looked, involving only a tiny prick and that he had gone through the procedure many times. Eventually he became the group's undisputed leader.

More and more, as his relationship to the worker and the children strengthened, Pat was able to express both anger and affection toward them, although he still reacted passively to the extremely painful and frightening treatments administered by nurses, doctors, and other therapists.

Role Playing

One evening, Pat and several other youngsters clamored for "a real hospital play." This meant that all the props had to be real. The groupworker got a stethoscope and several surgical masks and other instruments from the nursing personnel. The group decided, with Pat very active in the decision making, that the play should be about a patient's admission to the hospital.

That evening the group was composed of Pat, 3 other boys his age, 3 younger boys between the ages of 5 and 7, and 5 girls ranging in age from 5 to 11. All of them wanted to play the part of a doctor who had been especially sensitive to their needs. Pat and the oldest of the other boys won out. When the groupworker explained that other roles were also important, the girls accepted the parts of nurses. The role of patient, wanted by no one, was assigned to the younger children, who had the least status in the group. The role of the mother was discarded when Pat, as doctor, said that he would bring the patient to the hospital himself.

The play involved many injections and much knee tapping and taking of blood pressures. It finally wound up with the decision that the patient would ultimately die. At this point the group's interest seemed to wane, and the children moved on to another activity without showing much anxiety.

However, the next evening the groupworker had barely entered the ward before the cry was on for another play. "But," said Pat, "this time it is going to be murder."

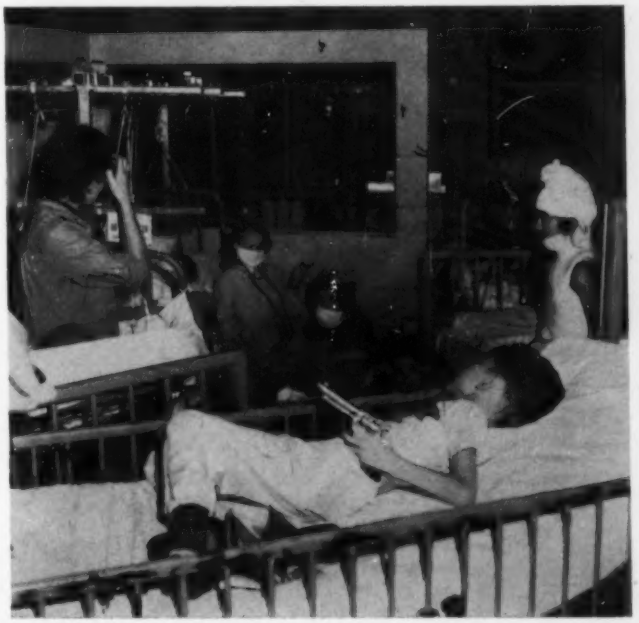
The group decided that the play might still center around the hospital and that the main figures should still be the doctors, but, at Pat's suggestion the doctors were to be the murder victims. The group's unanimity was unmistakable. Now nobody wanted to be a doctor, and the two youngest children were made to take the role. Pat and his close friend of the day before became the murderers and the girls became the police and judges.

The play took many forms—a chase, a capture, an escape, a trial, and another escape. When time came for the meeting to close, the worker tried to wind things up by asking how the play would end. With great vehemence, Pat, who earlier had decided the doctors had to die because "they hurt my pal," declared that the doctors had to remain dead; that the murderers would be caught and punished.

In the warm, nonthreatening atmosphere of a group, children often play out, or talk out, their anxieties and fears about the whole experience of being in the hospital, as Pat and his friends did in the two plays they created. The sick child's world is the hospital and the people in it are the important figures in his life. They are doctors and nurses, who may be friendly figures but who still can administer frightening and painful procedures, and other patients, who come and go. Sometimes a child may regard anyone who comes in from the outside, even his own parents, with hostility. This was evident in Pat's play when the mother role was discarded.

Sick children have to cope with the physical manifestations of what ails them as well as with the experience of pain. Their confusion may engender some fantastic ideas which may or may not come to consciousness. When they are hospitalized they often have the feeling that their parents have deserted them and left them in the hands of persons who want to hurt them. One of the purposes of the group is to help them bring these notions out into the open where they can be dealt with.

Play-acting can be therapeutic as well as fun. The "bad man" in the foreground, about to shoot the ether can and so put the doctors and nurses to sleep, gives the patient-actor, and the other children as well, a chance to discharge their feelings against the treatment received in the hospital.



As they chose or were assigned to their individual roles the children in Pat's group were investing themselves with a kind of therapeutic power. For instance, to be the doctor was to be the person who controls the lives and the comings and goings of sick children. To be able to identify with the doctor brought an opportunity to be as powerful and punishing and hurting and helping as he seemed to be. Through this role Pat played out some of his own feelings and ideas about doctors. He continued this the next evening by having the doctors killed.

In such play the groupworker brings in reality through assisting some children in their various roles, discussing what the play can really mean, and in many subtle ways helping the children to discharge their anxieties safely. At the same time, the children know and are reminded when it seems necessary that this is *not* "real"—but make-believe. They are aware that they are pretending to be powerful, to hurt, and to cure. There is discussion of the various roles played. At no time should youngsters play roles that would be damaging to them.

Getting Underway

To the groupworker accustomed to other settings, the hospital environment can be a strange, new, and amazing place. She is faced for the first time with large wardrooms, with children of all ages and all kinds and degrees of illnesses. The hubbub of various procedures, personnel, and parents can be a confusing experience.

At the Babies and Children's Hospital the pediatric casework supervisor had explained the purposes of the new program carefully to the nursing staff so that a start toward good relationships between nurses and groupworkers was already underway before the groupworker had even arrived on the ward.

Equally important in the evolution of the groupwork program was the help, support, and advice that the groupworker received from an advisory committee formed under the leadership of the director of social service. Several disciplines, including psychiatry, pediatrics, nursing, social casework, social groupwork, and education, were represented.

This committee met weekly for 2 years and followed the program closely in order to help to launch and reenforce it. The groupworker kept detailed process records of all her meetings with the children as the basis of her reports to the committee.

The committee helped to make decisions. It advised, for example, that the groupworker should meet with the children for four consecutive evenings each week in the period between dinner and bedtime, when staff activities had lessened and parents had left.

The committee asked many questions which helped the groupworker see her role more clearly, to weigh the value of various program media such as dramatics and games, and to consider other aspects of the group, such as the effect one child might have on another.

The committee also made suggestions about working with and communicating with the caseworkers, the nurses, and the doctors. It discussed the significance of the various mechanisms of defense as expressed by the youngsters in their play and talk and what response from the groupworker would be appropriate to each. They discussed the meaning of children's denial of their illnesses, identifying with the aggressive figure in the hospital environment, repressing frightening feelings about some of the hospital procedures, and general behavior.

After the groupwork program seemed to be running smoothly on the medical floor a social groupwork student from the School of Applied Social Sciences was assigned to it for her fieldwork experience. The worker moved to the children's surgical floor. There she observed a difference in reactions.

On the medical ward the fears and anxieties seemed much more on the surface, making it easier for the child to talk about them. The children there had to submit to treatment procedures but they could not see from where their illnesses stemmed.

On the surgical ward the group worker saw youngsters manifest great anxiety before surgery. Often the child could talk fairly freely at that time but afterwards evidenced complete amnesia about how he had felt before the operation. The surgery "had been fine," or there was "nothing to it." The advisory committee stressed the importance of not allowing the youngsters to repress these feelings. It advised the groupworker to make an effort to get at some of the same fears that had been present before.

Sometimes the worker was able to do this by helping a youngster who had been through surgery to explain to others in the group what it was like. She pointed out that these children might have had many fantastic ideas about what possibly could have happened. From the fairly safe vantage point of having gone through a frightening experience, it then became possible for the child to talk. This helped him to relive and to master in a much less frightening and less traumatic way some of his original fears and worries. Often too, reliving the experience in a play situation and under conditions

that the children themselves made was an effective therapeutic tool and a help in warding off greater anxieties.

In addition to helping the groupworker the advisory committee sponsored several teaching seminars for pediatricians, surgeons, social workers, and other interested personnel. Among other subjects they focused on: preparing children for anesthesia and surgery; the meaning of "shots" and other procedures to children and methods of understanding and handling their reactions; the effects on the children of radical surgery or death on the ward.

Staff Cooperation

The richest services to children have been in those instances where the collaboration between groupwork and casework has been immediate and intense. The groupworker is a member of the social service department. However, she works with all of the youngsters on the ward whether they are referred to social service or not, and whether or not they have special problems. Therefore she can spot youngsters whose problems are not immediately obvious, and can refer them to the caseworker.

Jimmy, aged 7, was an extremely quiet child. The personnel regarded him as "the model patient." He had been run over accidentally by his father, who was backing his car out of the garage, and was suffering from fractures of the back and jaw. The groupworker noticed his extreme depression, and his inability to take any part in the group activities. She also noticed the absence of his parents during visiting hours. She brought these observations to the attention of the caseworker.

When the caseworker talked to Jimmy she discovered that he was confused and terrified and did not know why he was there. She called his parents and discovered that they too were frightened and felt too guilty to come in to see Jimmy because "he might feel better if he did not see us." She worked with the parents until they were visiting daily, and with Jimmy until he was less frightened and depressed. Both workers conferred about Jimmy for a few minutes each day. Gradually he became more friendly with other children and began to participate in the group. He also became able to talk about his accident and his experience in the hospital in a realistic manner.

The groupworker's contacts with nurses and doctors go beyond clearance to see whether a child's condition permits participation in a group. Some staff members, when not under pressure, have taken part in the group activities themselves, thus giving the children an opportunity to see them in roles other than the accustomed ones. To be able to give play "shots" to "real" doctors and nurses has been a source of great gratification to some youngsters, and has helped them to express their feeling about the medical profession more freely. To get a glimpse of some of the real feelings youngsters have about them and about hospitalization in general has helped some of the doctors and nurses to greater understanding.

Although the groupworker has many contacts with the hospital personnel, the greatest avenue of exchange is the ward conference. This grew gradually from an informal getting together of caseworker, groupworker, and doctor to a regular weekly meeting of the caseworkers assigned to the ward, the groupworker, the internes, the chief resident, the consulting psychiatrist, the psychologist assigned to the pediatric department, the recreational therapist, the nurses, and students of the various disciplines.

The discussion centers on children who are referred or should be referred to social service. The goal is to formulate plans for better care for them while in the hospital and at the time of discharge, but a valuable byproduct is the constant learning and teaching.

The Values

The chief values groupwork can offer hospitalized children are reassurance and the opportunity to discharge tension in an atmosphere that is permissive and nonthreatening. We have observed the reassurances that these children can give each other are far beyond those that can be given by an adult, whose help, no matter how well-meaning, often appears as a new threat. As good as a relationship can be between children and adults, significant and understanding communication from one child to another carries greater weight.

Perhaps the child who benefits most from the groupworker and the group is the one who is helped to make the transition from a passive, compliant patient to a much more active, even aggressive one.

The program also provides reassurance to parents through the knowledge that their child is with other youngsters and with a warm and sympathetic adult.

From the hospital's point of view it is an important part of the team effort to help hospitalized children to have a less frightening hospitalization.

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[1] Coyle, Grace L., Fisher, Raymond: Helping hospitalized children through social groupwork. The Child, 16: 114–117, 126, April 1952.

Self-study in relation to changing times has led to . . .

NEW EMPHASES AT THE CHILD WELFARE LEAGUE

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RECENTLY the Child Welfare League of America, alert to the need for keeping its services abreast of changes in children's needs, made a detailed study of its functions and program. This study, financed by the Bernhard Foundation and directed by Katharine F. Lenroot, formerly chief of the Children's Bureau, has been published in a booklet entitled "Today and Tomorrow." Some of the thinking which brought about its findings and the current activities and plans for the future to which they have already led will be outlined here.

Services to children and, more important, the needs of children have changed radically since the League was founded in 1920. If the League is to continue to be useful it must gear its program to the changing needs of its member agencies and the children for whom they are responsible.

At its founding the general mandate to the League was improvement of all forms of service to children. Over the years it has worked in this direction mainly through its function as an accrediting agency and by providing information on sound child-welfare practice. It has developed a variety of activities: staff consultation with member agencies; publication of professional materials; periodic regional conferences on child welfare; the conducting of child-centered community or agency surveys; coordinating an interagency service for children needing such care.

Through these efforts, and those of many other persons and organizations, tremendous strides have been made in the child-care field since 1920. In that year the evils of baby farming were being exposed. Large congregate orphanages were only beginning to be replaced by cottage-type institutions. In many States children still worked long hours in factories. Homeless children were sometimes shipped on special trains from large cities into smaller towns where they were stood up in churches and chosen for free foster homes by more or less well-meaning people. Adoption of homeless children was only beginning to become "respectable." Social casework was just beginning to have an impact in the child-welfare field.

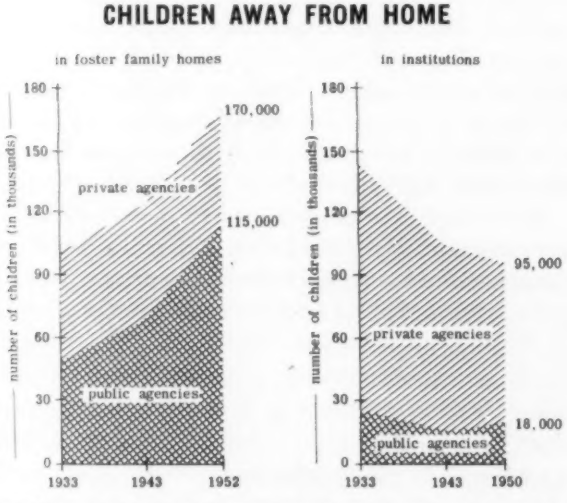
Conditions Today

The changes over the years have reflected a gradual awakening to children's longtime needs as well as a response to new needs. Among children's institutions 25 percent have refocused their operations from giving custodial care primarily to serving as specialized resources for children who cannot live in an ordinary community setting. Skillfully planned foster-home placement has replaced the practice of putting children into free homes. New resources such as day-care centers, foster-family day care, and homemaker service are beginning to prevent many long-term, full-time placements. Adoption has changed from a dubious, seldom-used method of providing care for children, to an extremely popular one in which the present problem is a too short supply of the kind of infants in demand. Improved public-assistance programs, family-welfare programs, child-guidance clinics, and counseling services have had immeasurable effect in reducing the number of children who must be cared for away from their own homes.

With reduction in the number of orphans and

others with long-term dependency needs we have been able to give more attention to the treatment of children with personality disturbances. This move has been greatly accelerated by developments in psychiatry and by the interdisciplinary exchange between social work, psychology, and education. Today narrow lines of specialization are breaking down. The various professions and branches of professions concerned with delinquents, school social work, child guidance, and foster care are recognizing their common interests. All of these developments have been achievements of a public more sensitive to the needs of disadvantaged children.

Despite these gains, the 250 member agencies of the League reporting on local conditions for the study revealed that many, many children needing service are still unserved. Thousands of older children, handicapped children, and children from minority groups are deprived of permanent homes, due to the lack of adoption resources for them. Thousands of emotionally disturbed children who could be helped, were facilities available, are growing up to become social misfits, criminals, or patients in State mental hospitals. Sadly inadequate correctional resources reflect in great part the philosophy of half a century ago. In many parts of the country child-welfare caseloads, particularly in public agencies, are so high that children get but casual care. In some areas practically no services are open to Negro children. Hundreds of children's institutions without casework service take children under care not knowing whether or not they really need care away from home and are unable to maintain valid contacts with the children's families. "Black" and "gray" markets in adoption have sprung up and are flourishing. Thousands of substandard commercial day-care homes and commercial foster homes present a serious hazard to children.



Children in foster-family homes have increased over the years as the institutional population has declined.

Against this background we have planned the League's future program. Among its implications are the following:

1. ***A different type of field service, expanded in scope, is necessary.***

Back in 1920 when the League was started there were few well-trained social workers in the child-welfare field. The task of the League's staff then consisted in large part in going into a community and "telling" people what a good child-welfare program was and helping them get one started. In this way the League was in part responsible for the development of many State departments of public welfare, the framing of State child-welfare laws, and the reorganization of many private agencies.

Today, however, all the States and a great many localities contain well-qualified social workers in the child-welfare field. They know what good programs and good standards are, and they are striving to achieve them. The League's function has shifted to that of a "communicator" and a "management consultant." This includes the responsibility of keeping abreast of nationwide trends that may not be discernible in any one town or any one State and of new methods developed by one community that might be helpful to others. Through field consultation the League helps member agencies by impartial reviews of their programs.

However, the League is conscious of many areas in which the needs of children are not being provided for even on what we know to be essential minimums. For example, 25 years ago the League began efforts aimed toward ending the institutional care of infants and very young children. Since then over 200 institutions have recognized the harm such care can do to the child's emotional development and have abandoned it, usually developing foster-home care for the very young instead. Nevertheless many, many institutions remain that either do not know of or do not heed the extensive research which has revealed the psychological damage which can occur through early institutional care.[1]

There are still hundreds of child-caring agencies outside the stream of professional social work, agencies that do not have caseworkers or diagnostic re-

sources to determine whether the children and families they serve actually need or can benefit from what they can offer. The League must continue to persuade the boards of such agencies of the necessity for professional services and to help the agencies obtain them. Therefore, the study recommended that the field-service program to both member and nonmember agencies be accelerated.

2. *Child-welfare practice must reflect modern scientific knowledge.*

The study strongly recommended that the League do its utmost to promote interdisciplinary cooperation in the child-welfare field and to encourage the fuller utilization of the findings of other fields. Anthropology, genetics, sociology, psychiatry, pediatrics, psychology, law, and religion all have rich contributions to be made to the care of children. Often new findings in those fields are not known to children's agencies, and, conversely, often the problems and knowledge of children's agencies are not known to the representatives of these disciplines.

The League is a standard-setting and accrediting agency. Standards of practice must reflect the best scientific knowledge available from all sources. A major revision of standards in the child-welfare field has not been made on a national basis during the past 15 years. The study recommended such a revision as a top priority.

This recommendation is already being acted on through the generosity of the Ittleson Foundation of New York City. A substantial grant from the Foundation will enable the League, in the next 3 years, to reassess and redraft standards in all areas of child welfare, including foster-home care, institutional care, adoption, homemaker service, service to unmarried mothers, and work with children in their own homes. In this task the League will work with the Children's Bureau of the U. S. Department of Health, Education, and Welfare, the Family Service Association of America, other national agencies, its local affiliates, councils of social agencies, and State departments of public welfare. It will draw upon all available resources in related fields, with the object of producing a dynamic document which will reflect the best current knowledge.

The League plans to keep standards up-to-date in the future by reviewing them at frequent intervals and changing them where subsequent knowledge proves a standard outmoded.

Shortly the League will publish the results of its second national adoption conference. This conference was preceded by a study financed by the Rosenthal and Heinz Foundations, of adoption practices in over 200 adoption agencies in the United States. The findings were correlated and distributed to a group of persons representing various social and biological sciences. These scientists met with 300 adoption workers in Chicago earlier this year and closely examined the practices of adoption agencies in an attempt to determine which could be scientifically supported, which were unscientific, and which needed further research to test their validity.

One result of this conference was the realization that perhaps no field in child welfare is changing more rapidly than adoption. Practices that were considered the very best but 5 years ago are now outmoded. Agencies are experimenting with new and dramatic ways of finding homes for children heretofore thought unplaceable. They are discarding some former "safeguards" as unnecessary; they are improving diagnostic methods and are willingly subjecting their every practice to the scrutiny of others. The League's work in keeping participants in the adoption field closely in touch with each other will continue and will serve as a pattern for its services to other fields of child care.

3. *The research program of the League must be greatly stepped up.*

One type of research should be directed at ascertaining trends that will affect child-welfare programs.

Since a large percentage of all children in institutions in this country today are emotionally upset it is essential that outmoded institutions adjust their programs to provide treatment resources for children who have been so damaged that they cannot live in a family setting. The League is currently conducting a detailed study, financed by $26,000 in foundation funds, to determine what is happening in some 500 children's institutions. This research has been preceded by a 2-year study of residential treatment centers, which has revealed ways in which institutions can improve their services to disturbed children.

Another facet of the League's research is in probing conditions of child care, searching out weaknesses and finding ways to improve them. One way the League is extending this part of its program is through embarking on a 3-year action-research project, a scientific study of conditions of children in foster care in the United States. Financed by the Field Foundation, this study is in part patterned after the research recently conducted by the Citizens'

Committee on Adoption in California. It will attempt to find the obstacles that have prevented agencies from making permanent plans for children and that have resulted in children remaining in foster care longer than necessary. In studying cases of individual children it will appraise the effects of laws relating to the rights of parents, and the absence or presence of professional personnel. It will attempt to determine how many children in foster care could be made available for adoption, were resources available, and what resources are needed.

It is hoped that by studying States that have various patterns of social-service structure or laws, some clues will be found as to the best methods for insuring children permanent homes. In each State or area studied a citizens' committee will be enlisted to work with the research staff, to serve in an advisory capacity, and as an action group to improve conditions of foster care.

The League will also add a staff member to study existing State adoption indexes, such as the one in Ohio. The purpose will be to formulate a uniform system of indexes and encourage all States to establish this type of clearinghouse for bringing agencies with children for whom homes cannot be found in touch with agencies having prospective adoptive parents but no children. When a sufficient number of States have created such indexes, the League will set up a national adoption index. It is hoped that many hard-to-place children will find homes through such a device.

Through its work with the United Community Defense Services the League has found that the tremendous increase of defense industry, atomic-energy installations, and the movement of Army camps have resulted in many children being cared for under harmful conditions. The absence of day-care facilities for working mothers is a major contributing factor. Having studied this situation, the League has worked with defense forces and atomic-energy plants in an attempt to develop better day-care programs and other facilities for young children.

Research can also help to improve the efficiency of social agencies. In collaboration with the Children's Bureau, U. S. Department of Health, Education, and Welfare, the League is conducting a joint study to develop better methods of cost accounting for children's institutions. Financed by grants from the New York Foundation and the New York Fund for Children, this project is attempting to develop a uniform method for determining costs of various phases of an institutional program and for various types of children. Such a method would enable institutions to compare costs and, to a degree, program efficiency.

4. The League must become far more active in community organization.

The form in which social agencies are organized in a community greatly affects their efficiency and economy. For instance, multiple-service children's agencies are apt to provide better service for children than a number of unconnected agencies. The League is interested therefore in finding out what other forms of organization are efficient—for example, whether all services needed by unmarried mothers should not be provided in a single agency rather than being spread among three or four, as is commonly the case.

However, a great deal of study is necessary to determine what combinations of services have proven most worth while and under what circumstances. Today there is a great deal of loose talk about the advantages of combinations of agencies, with some specialists in community organization recommending that practically all social, psychiatric, and health agencies be merged into one. No systematic study has ever been made of this problem. The Family Service Association of America and the Child Welfare League are currently seeking funds to conduct a joint study of the results of various types of mergers, particularly of family and children's agencies, to determine what conditions make for the most successful merger and what conditions are conducive to failure.

Today communities are beset with what is often a serious imbalance of resources. Some areas have good foster-care programs but very weak programs of aid to dependent children. Such an imbalance results in some fatherless children going into foster care because their mothers, for economic reasons, cannot care for them. Again, a community may have a good family agency, a child-guidance clinic, and a good foster-care program, but no protective services, with the result that some of the most desperate situations go unobserved until the child forcibly brings them to public attention by becoming seriously delinquent. Another community may have good institutions and good foster-home-care programs, but be completely lacking in homemaker or day-care programs which can serve some children far more adequately than removal from home. Much greater investment needs to be made in such programs almost everywhere if well-rounded services to children are to be developed.

5. ***The general public's unawareness of child-welfare needs is perhaps the greatest obstacle to improvement.***

Before any child-welfare organization, local or national, can achieve marked improvements in program, greater effort must be spent in public education. Ours is a rich country. I believe that most people would be willing to spend tax dollars or give private contributions to aid children, if they knew why such aid is necessary. Unfortunately, large segments of our population have no idea of what we mean when we speak of the quarter-million children who must be cared for outside their own homes. Most of them think we mean orphans, though the full orphan has almost disappeared from our population. They may believe in providing decent shelter, food, and clothing for them but be completely unaware that psychological starvation is by far the greatest problem of most of these children. Fortunately, our national media of communication give evidence of growing public interest in these problems.

The League is working cooperatively with one national TV and radio network to insure accurate interpretation. It helps many popular magazines with articles on child-welfare subjects. Currently it is producing a film on foster care with one of its member agencies.

A Task for Many

In addition to these major recommendations the League's self-study contained many having to do with the organization's internal programs. Most of them are concerned with strengthening and improving various aspects of its service to member agencies: its membership studies which serve as a base for accrediting child-welfare agencies; its regional conferences which serve as educational tools for the field; its employment service for child-welfare workers; its relationships with other national organizations; and its international program.

The League is but one of many organizations in this country that can help improve conditions for children. Over 1,800 private agencies in the United States concentrate exclusively on providing children with foster care. Public agencies in most of the 3,000 counties carry on similar activities in addition to other services to children. Leadership and stimulation in raising the standards of care provided by these thousands of child-caring agencies must come from many sources—public and voluntary. Councils of social agencies, State departments of public welfare, the American Public Welfare Association, the Children's Bureau of the U. S. Department of Health, Education, and Welfare, all bear a major responsibility in this regard.

We hope that eventually the outworn tag of "dependent and neglected children" will be dropped. We also hope that the resources of social work, of psychiatry and psychology, of guidance clinics and foster-care agencies, will be recognized as services directed essentially toward the same children.

Practically all children in foster care today come from situations that breed emotional disturbance. They represent one of the most vulnerable groups of children in our population. Because of the long association of the care of "dependent and neglected children" with a pure problem of custody, few of them had the attention of the behavioral services. There is a dearth of research regarding effects of foster care on children or on determining what conditions in foster care are conducive to sound psychological growth and what are harmful.

In many areas it is still the privilege of any person, regardless of background or ability, to set up an organization to care for children. So far no one has come forward to suggest that it should be illegal for any organization to attempt to care for children unless it has adequate professional personnel for determining whether they need care outside their own homes and unless it has the use of casework staff for working with a child and his parents toward eventual restoration of the child to his own home or toward another permanent plan, such as adoption.

We can also hope that in the near future there will be universal recognition of the institution as a specialized resource. Institutionalization is not a way of life for children, but rather a means to an end—a resource to serve special needs, the needs of children who for certain reasons cannot live in a more normal community setting but who can benefit by the unique contribution of group care.

Fulfillment of hopes depends upon action. At the League it is believed that the study of its program will serve as a chart for action. "In so doing," states the report, "the League will not only contribute to the welfare of children and young people throughout the Nation, but will strengthen the foundation of our country's life by helping children to grow into citizens who are strong enough to love freedom and wise enough to cherish and use it."

[1] Bowlby, John: Maternal care and mental health. New York: Columbia University Press, 1951.

INTERNATIONAL STUDIES ON GROWTH AND DEVELOPMENT

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STUDIES OF GROWTH and development in the normal child have always been connected with North America by European workers. The reason is clear: the amount of work in this field carried out in the past and at present in the United States is very large. Comparatively, the reverse is true of European countries, and of most others. Because of the paucity of modern information available on this subject outside North America, a study of the growth and development of normal children was started in London in 1949.[1]

At this point it is necessary to review briefly the situation in this field up to this time in the United Kingdom. For the purposes of this article the only types of studies under discussion are "longitudinal"; that is to say, studies which follow the *same* children over a period of growth. Very few standards of growth are available in Europe other than those based on "cross-sectional" data—or data available on large groups of children at various ages. Even these data are in the main sadly out of date.

In Scotland, a longitudinal study was carried out on boys and girls in 1927 by Professor Alexander Low, and some standards of anthropometric measurements have recently been published.[2] The Social Medicine Unit in Oxford started a study in 1943, but most unhappily this was terminated in 1952 through lack of funds. Data from this study have been published, and excellent publications continue to appear.[3, 4]

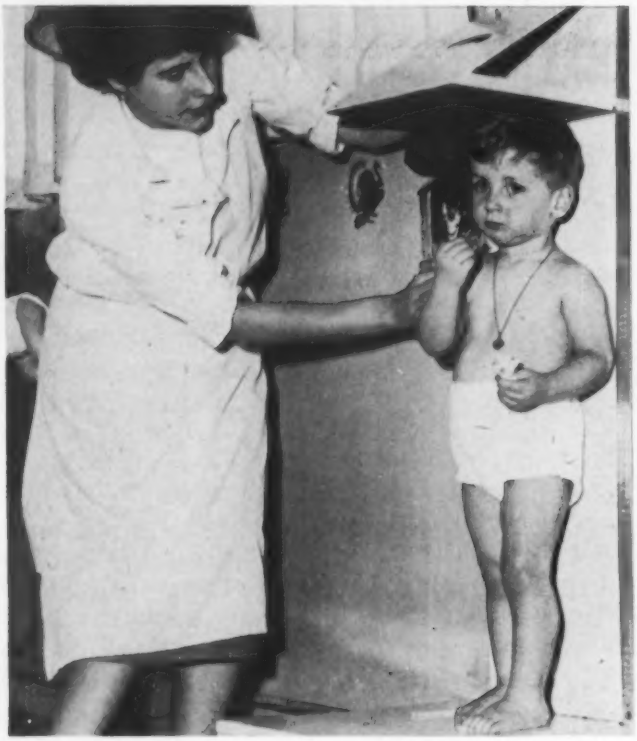
In 1948 a study jointly sponsored by the British Ministry of Health and the Sherrington School of Physiology, St. Thomas' Hospital, London, was begun which actively continues. The subjects are children living in one of the centers of the National Children's Homes, an organization caring for orphaned or deprived children. While the children may enter the centers at almost any age, on the whole this study concentrates on the older child. The investigations are most comprehensive. A large team of specialists attend the regular monthly sessions when data are collected. However, no psychological investigation into the mental development of the children is carried out. Moreover, the sample is somewhat selective. This study and those in Scotland and Oxford seem to have been the only reasonably recent longitudinal growth studies in Europe preceding the establishment of the London study in 1949.

The London study was jointly set up by the Institutes of Child Health and Education in the University of London. It was planned from the start as a fully comprehensive longitudinal investigation on "normal" children from birth to maturity. The oldest children in the sample are at present approaching 4 years of age.

In this project the growth of the children is studied physically and psychologically while full recognition is taken of antenatal, postnatal, socioenvironmental, nutritional, and genetic influences. The basic team of investigators consists of two psychologists, a pediatrician, two research assistants, and a secretary.

Continental Studies

In 1952 a happy series of events occurred. As a participant of this study I mentioned in a short paper read at the annual meeting of the British Paediatric Association at Windemere that there was a dearth of comparative information available upon growth from different countries. I added that, ideally, national growth studies could compare information which, apart from their individual value, would yield valuable data upon racial and other influences affecting the development of the children.



A French child contributes information to the Paris growth study. *Left,* his physical growth is measured. *Right,* he participates in a psychological test. Studies under way in five other countries are coordinated by the Centre International de l'Enfance.

These remarks prompted Professor Robert Debré, the French pediatrician, and president of the Council of the Centre International de l'Enfance in Paris, to get together with Professor Alan Moncrieff, Nuffield Professor of Child Health in the University of London, and myself. The three of us planned an entirely imaginary growth study to be set up in Paris and to be sponsored by the Centre International de l'Enfance. This, we dreamed, would run on lines exactly parallel to its London twin.

Could we make this imaginary plan a reality? Many difficulties had to be overcome.

The first step was taken in 1953 when I was invited to work in Paris with the Centre International de l'Enfance for that year, and was granted leave from the Institute of Child Health in London. My duties were to collect a team of French investigators and to spend the year setting up the new French study under the auspices of the Centre. My job was not to teach French scientists how to run such an investigation—a task they were perfectly capable of performing already—but to make sure the two studies were parallel. Moreover, I could see that the Paris study was not hampered by the mistakes we had made in starting our London study.

Although the Centre International de l'Enfance is administratively run by the French and is located in Paris, its activities are directed by a Council which is international in the true sense of the word. Partly financed by UNICEF, its ever-broadening activities include: running postgraduate teaching courses on a large and worldwide scale; providing an excellent bibliographical service; and conducting extensive research. It was therefore natural for the Centre to encourage a project involving cooperation between two groups of workers in different countries.

During that year of 1953 the work of getting the Paris study underway continued and various feelers were put out with the aim of extending the project further. When a Swiss member of the Centre's Council expressed keen interest I paid a visit to Zurich where a study was being planned. The pediatrician who was to run the Swiss study then spent a month with us in Paris learning the techniques and methods common to the Paris and London studies. Then the Swedish and Belgian members of the Council expressed interest in setting up cooperating studies in Stockholm and Brussels.

The snowball had started rolling and was getting a bit heavy. It was clearly time to review the whole situation and organize ourselves. Many meetings occurred during the next 6 months as these studies got

underway. In October 1954 the first international "working-party committee" of these studies, and others proposed, met in Paris under the auspices of the Centre.

International Cooperation

The committee faced a major question: if various countries were going to run studies on growth of normal children would it be possible to agree upon a common "baseline" of investigations? It was considered extremely important for each national study to be free to follow whatever particular lines of research it wished. No one ever suggested that any central organization should direct what should or should not be investigated. Nevertheless, if the different countries *were* going to carry on such studies, then a common simple baseline to be followed by all would be invaluable for comparing data. It would be a tremendous pity if this great opportunity were lost.

By the time of this meeting, the London, Paris, and Zurich studies were already underway and the Stockholm and Brussels studies were ready to start. Representatives from all these countries' working teams were present at the meeting along with various experts invited to criticize and help. The miracle happened: we fairly quickly agreed on a clear-cut basis for investigations under the main headings: antenatal, postnatal, health, socioeconomic, and anthropometric factors. This was not accomplished overnight nor without some diplomatic measures which might have surprised experts in the United Nations; but it *was* accomplished and with great good humor.

The most difficult task was for a subcommittee composed of a group of international psychologists to reach agreement about the factors to be included in regard to the all-important psychological and emotional development of the children in the studies. There were many points of argument: to "test" or not to "test"; to "interview" or not to "interview." Nevertheless, the subcommittee did arrive at a "baseline" for material on mental and emotional development and this is widely comprehensive.

The common baselines of investigations, as we call it, is published in restricted form for the use of the workers in the various studies.[5] It is but the first, we hope, of several guides.

The committee stressed a vital point: a growth study must grow and change. Methods alter. The children develop. Therefore the Centre agreed to sponsor an annual meeting of representatives from the various teams so that results can be compared, methods criticized, and improvements planned continuously.

At the time of writing the London, Paris, and Zurich studies are progressing, while pilot studies have been started in Brussels and Stockholm. Two other studies are planning to use suitable parts of the "baseline"—one in Dakar directed by Dr. Jean Sénéchal, and the other in Kampala directed by Dr. R. F. A. Dean. These two African studies are highly specialized and deal with malnourished children. Together with the studies in Zurich, Stockholm, and Paris, they are financially aided by the Centre.

A Growing Snowball

There is also a possibility that an American team will attach itself to this snowball of international cooperation. A year ago, at the instigation of Dr. Alex Steigman, professor of child health in the University of Louisville, I spent a month in the States, where we discussed plans for a project in Kentucky and where I had a chance to discuss the "baseline" with experts from the Children's Bureau of the U. S. Department of Health, Education, and Welfare. The Kentucky study would investigate the normal growth of Negro and white children.

Clearly the snowball grows and there is no evidence that it has come to rest. At least we hope it will produce reliable international data—surely a great reward for pushing it off down the hill.

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An essay-review . . .

CULTURE AND PUBLIC HEALTH

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MUCH HEADWAY has been made within the past 20 years in developing techniques of getting across ideas in public health. During the early part of this period the emphasis was upon the use of different media and when this was done for people of the same culture the results were usually quite successful. We recognized that people of different educational and environmental backgrounds would react better to materials geared to these backgrounds.

We even developed material in other languages if necessary but these were usually translations of materials developed for English-speaking people, not materials specifically designed for people of other cultures. If, in addition, we used illustrations depicting the race for which the material was developed, carrying out the recommended procedures, we felt the adaptation was complete.

The fact that these materials were frequently quite popular and successful gave us an even greater feeling of confidence.

One of the earliest agencies to recognize that this was not sufficient was the Bureau of Indian Affairs, U. S. Department of the Interior, which used ethnologists, cultural anthropologists, and sociologists to interpret to their staff the cultural differences of the tribes with which they were working and how teachings would have to be modified to make them acceptable to the people.

When the United States became interested in helping Latin-American countries and when we took part in the technical-aid programs the importance of understanding the cultural backgrounds of the peoples receiving service was brought home to us even more forcefully; and the sociologist, cultural anthropologist, and community worker became part of the health team. Many reports of their experiences and conclusions are available and are well worth studying.

Now recently the University of Colorado School of Medicine has realized that it has not been as successful in obtaining acceptance of its recommendations regarding health among its Spanish-speaking patients and so has added a sociologist to its staff, Lyle Saunders, associate professor of preventive medicine and public health.

He has been successful in interpreting to the staff and students the cultural differences that must be taken into account in understanding the frequent failures to obtain acceptance of Anglo medicine.

A Help to Understanding

Much of this material he has gathered together in a volume "Cultural Difference and Medical Care" recently published by the Russell Sage Foundation.[1]

He has developed a very readable book which should not only be of assistance to all physicians, nurses, welfare workers, teachers, and others working with cultures other than their own in accomplishing their objectives, but should make their task a much more pleasant one because it will help them develop an understanding, liking, and sympathy for the people with whom they are working.

The book will be particularly valuable for those working with Spanish-speaking people in the field of medical care.

The author gives the book a very human quality by describing in the first chapter the occupants of a

house made into apartments in the Spanish-speaking section of a large Southwestern city. It is occupied by Spanish-Americans, Mexican-Americans, and people recently arrived from Mexico. Their health problems, the differences in their attitudes, and the situations that arise from these are related.

In the later chapters, discussing the cultural background, differences in culture and the problems these cause, and the folk medicine of the different groups of Spanish-speaking people, the actions of these families are interpreted and we realize how very logical, in the light of this background, some of their seemingly illogical actions may be for them.

The fifth chapter is devoted to programs that have been set up to provide medical service for Spanish-speaking people and why some of them have failed, and how the gap between the two cultures may be bridged.

The last chapter is devoted to the importance of a background of the social sciences and humanities as well as the present medical- and nursing-school curricula in permitting each worker in health to "make more effective use of all their knowledge and abilities and thus contribute to the attainment of their individual and collective goals."

The notes to the chapters should not be overlooked—they are unusually meaty.

For people working with Spanish-speaking people this book is a must. Even if they are themselves Spanish-speaking, and have worked with Spanish-speaking people for years, they will enjoy seeing all of their impressions and bits of knowledge knit together in an understandable whole. For those who have less experience, a careful reading and digestion of this book could add much to their efficiency and acceptance.

Public-health administrators should find this book an excellent stimulation to reevaluating their programs in the light of their effectiveness when applied to a different cultural group.

When the acceptance of the fact that the cultural background and attitudes of the people we wish to reach is just as important a factor as the health concepts we wish to impart in the final goal of improving the health of a people, our entire approach to the problem takes on a broader focus. We become very much more concerned with our acceptance by these people as individuals and as members of a health organization. Will they accept a statement regarding health just because we advance it and say that well-known health authorities (who are unknown to them) state that this is the best procedure? Or must this information be related to something already known and acceptable to them?

There are several generalizations we can safely make regarding our approach to all cultures. The learning situation should be as pleasant, relaxed, simple and free of tension-producing content as possible. We should start with health content that is easily understood, is probably readily acceptable because it is in harmony with attitudes and beliefs now held, and which produces easily discernible improvement in a short time. No health practice should be changed, however markedly it may differ from accepted Anglo health practices, unless it is definitely injurious to health.

Beliefs and Attitudes

Public-health workers should be thoroughly familiar with the cultural background, beliefs, and attitudes of the group with which they are working. This includes relationships within the family and community. How often do we expect a woman to make an immediate decision regarding something such as hospitalization of herself or her child when her culture demands that she consult her husband or her father or brother or even the official council of her village? How often, in order to improve nutrition, do we recommend the basic seven foods in terms of Anglo foods when these are too expensive, unacceptable because of taboos, or undesirable because of their lack of keeping qualities under the conditions that exist, when a few minor acceptable changes may be all that is necessary to produce an optimum diet?

Do we have a proper appreciation of health practices of other cultures which have developed through years of experience and which may be much better suited to their particular situation than our practices based on a highly urban civilization?

A very thorough examination of our present public-health programs for other cultures, stimulated by these and similar questions with regard to applicability of our present health concepts and approaches to other cultures, will not only help to achieve a much more rapid acceptance of these concepts most necessary to survival but will make us clearer thinkers, better teachers, and persons much more understanding of the people of this world and of why they act as they do.

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[1] Saunders, Lyle: Cultural difference and medical care. New York: Russell Sage Foundation, 1954. 317 pp. $4.50.

BOOK NOTES

PREMATURE INFANTS; a manual for physicians. Ethel C. Dunham, M. D. Second edition, completely revised and reset. Paul B. Hoeber, Medical Book Department of Harper & Bros., New York. 1955. 459 pp. $8.

First published in 1948, under the same title, as Publication No. 325 of the Children's Bureau, this book is planned as a source of information with regard to prematurity and a guide for the general care of the premature infant.

Part I deals with general considerations—definitions of and criteria for prematurity; incidence, causes, and prevention of premature birth; and the growth and development of premature infants. Part II discusses the physiologic handicaps of premature infants, the general problems of their care, and the congenital and acquired conditions that tend to affect them adversely. Part III outlines some of the public-health aspects of prematurity, including death rates and causes of death, and cites examples of organized programs for the care of premature infants and for the prevention of premature birth.

EDUCATION OF MENTALLY HANDICAPPED CHILDREN. J. E. Wallace Wallin. (Education for Living Series, edited by H. H. Remmers.) Harper & Bros., New York. 1955. 485 pp. $4.50.

Besides giving detailed consideration to the training and education of mentally handicapped children, this book briefly discusses their socioeconomic problems.

Much of the contents is concerned with the organization, administration, and objectives of special classes for these children.

CULTURE AND MENTAL DISORDERS; a comparative study of the Hutterites and other populations. Joseph W. Eaton in collaboration with Robert J. Weil. The Free Press, Glencoe, Ill. 1955. 254 pp. $4.

The Hutterites, a communal religious group whose colonies are located in Canada and northwestern United States, were selected for study of their mental health, according to the authors of this book, because of their reputation for peace of mind. But, the authors say, "Our findings do not confirm the hypothesis that a simple and relatively uncomplicated way of life provides virtual immunity from mental disorders."

As for the formative years of these people, the book reports: "The growing Hutterite child is molded consciously and consistently by parents, teachers, and the impact of all community institutions. The goal of this fairly rigid and deterministic socialization process is the making of an adult who will live in conformity with the expectations of the Hutterite way of life. . . . Permissiveness in child rearing is not a Hutterite virtue; it is regarded as a vice."

OUR BACKWARD CHILDREN. Karl F. Heiser. Foreword by Grover F. Powers, M. D., W. W. Norton & Co., New York. 1955. 240 pp. $3.75.

Addressed to parents, psychologists, pediatricians, psychiatrists, neurologists, social workers, educators, and institution administrators, this book offers concrete advice concerning mentally retarded children.

The author maintains that such children's deficiencies are symptoms of underlying pathological conditions. He looks forward to prevention of these conditions and points to what he considers the paramount need, well-planned research.

He particularly urges differentiation between the child who is mentally defective and the one whose low IQ is due to emotional disturbance.

MIDWEST AND ITS CHILDREN; the psychological ecology of an American town. Roger G. Barker and Herbert G. Wright. Row, Peterson & Co., Evanston, Ill. 1955. 532 pp. $7.50.

"Midwest," as used in this report on children's "psychological living conditions and behavior," is the pseudonym selected by the authors for a typical small town in which they and their staff systematically observed and recorded children's behavior, not in psychological laboratories, but in the children's natural habitats. For comparison they included also a few physically handicapped children living in neighboring towns and in a school for the crippled.

The authors express the hope that in the future "psychological situations will be mapped as the physical areas of the world. . . . when changes in psychological living conditions and behavior will be as carefully plotted and scanned as changes in birth rates."

SCHOOLS IN TRANSITION; community experiences in desegregation. Edited by Robin M. Williams, Jr., and Margaret W. Ryan. University of North Carolina Press, Chapel Hill. 1954. 272 pp. $3.

Some of the recent experiences of 24 communities in States bordering the South as they moved from racially segregated to integrated public schools are described in this book. The editors have divided the communities studied into two main classes, those in States whose laws required integrated schools and those in States whose laws on this subject were permissive rather than mandatory.

In communities that had a tradition of activity in intergroup relations investigators found that the transition seemed to take place with relative ease. They found also that public-school desegregation or integration only loosely correlated with the attitudes of the population: in some places school desegregation was successful in a completely segregated environment.

Where desegregation has been tried, the editors say, the typical outcome has been its eventual acceptance. The ease of transition varies greatly from community to community. Some resist the change more than others, but the direction of change is clearly toward acceptance of educational integration.

BEHAVIOR AND MISBEHAVIOR; a teacher's guide to action. James L. Hymes, Jr. Prentice-Hall, New York. 1955. 140 pp. $3.

The author divides children into two groups, the stable and the troubled, and tells the teacher that her skill in teaching discipline depends on her ability to distinguish between them. He suggests methods of helping both groups, and says: "No one way is always good in general, nothing always bad * * * Only one rule is constant: You must determine the cause, and your action must be consistent with the cause."

PROJECTS AND PROGRESS

The United Nations and Juvenile Delinquency

The First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, which met at Geneva, Switzerland, August 22–September 3, 1955, called for a United Nations study to assess the practical results of various measures aimed at preventing juvenile delinquency. The resolution suggested that nongovernmental agencies with special knowledge in the delinquency field be asked to help in the necessary fact-finding.

Why this type of study needs to be added to the extensive research program on delinquency already being carried on by the United Nations came out clearly in the section of the Congress devoted to the prevention of juvenile delinquency. This section included about half of the 565 official and unofficial delegates representing 66 nations at the Congress.

Members of the section explained conditions in their countries related to delinquency and described measures intended to help boys and girls in danger of becoming delinquent. These measures fell into four categories in relation to: (1) the community; (2) the family and the school; (3) the social services, including health services; and (4) other agencies, such as religious bodies, the police, and leisure-time organizations. In telling about them the delegates repeatedly pointed to the need for scientifically developed, objective research that would show which measures are succeeding and which are not.

Nearly all the reporting delegates spoke of rising delinquency in their countries. A number attributed this trend to increasing industrialization. Delegates from Israel, Iraq, Pakistan, India, and Syria reported that in their countries families are crowding into cities in the hope of making a living somewhat better than a bare subsistence level and that the sudden change from rural life often leads to family disorganization and hence to delinquency.

The delegates from Syria and Pakistan also attributed some delinquency to conditions among large numbers of refugees in their countries from elsewhere.

United States delegates reported on research aimed at finding ways of identifying potential delinquents at an early age.

Countries that reported favorable trends in juvenile delinquency were the United Kingdom, which in 1954 found juvenile delinquency reduced 18 percent below its incidence in the preceding year; France, which experienced more than a 50 percent decrease between 1946 and 1954; and Greece, which in 1954 experienced a slight decrease from 1953.

French delegates reported that in their country social agencies concentrate on family education. They send experts into homes to teach mothers how to care for children. They also send busloads of city children to vacation colonies in the country. Police associations form "teams of friendship" with children.

In the United Kingdom local coordinating committees integrate the activities of agencies giving services to prevent delinquency, delegates said. Special welfare offices work with boys and girls committed to institutions, and with their families, to prevent recurrence of offenses.

Israel was reported as tackling delinquency prevention through health centers, through recreation centers and through "youth-to-youth" programs under which children of different economic backgrounds get together and learn about one another's problems.

Egypt has more delinquency in the part of the country becoming urbanized than in the part remaining rural, an Egyptian delegate said. He reported that many services to deal with delinquency have been established during the past year—a social-service unit for every 50,000 of the population, recreation centers for delinquents, training schools for delinquents, treatment and observation homes, and probation bureaus.

In Denmark youth clubs under the auspices of the police seem to be bringing good results, according to a Danish delegate. The Government pays 45 percent of the cost of operating these clubs, the locality 3 percent, and the remaining 52 percent comes from membership dues and gifts.

After discussing such preventive measures, the section prepared a report which the Congress adopted unanimously for submission to the United Nations Economic and Social Council.

The report puts major stress on the need for research. In addition to the evaluative studies the Congress has asked of the United Nations, it suggests investigations into the causes, diagnosis, treatment, and prevention of juvenile delinquency. Because accurate knowledge in these fields lags far behind the good intentions of those interested in increasing social action, it suggests that whenever such action is undertaken, provision be made for evaluation of results.

The report also calls attention to the indirect measures that help to prevent juvenile delinquency, such as housing and public-health programs, but it warns that projects for general social improvement, such as these, cannot do the whole job, that programs specifically for delinquency prevention are indispensable.

All public and voluntary programs for children and youth in a community should be drawn together closely, with a specialized agency such as a coordinating council or community committee to integrate the various services, the report advises, so that more children with serious difficulties can be served in the way best suited to the child's and his family's needs, while duplication of services is avoided. It also advises closer collaboration among individual workers.

The report emphasizes the importance of reaching a child through his family rather than by direct agency intervention and of fostering family ties and a sense of belonging in the child. It suggests that young persons be helped to cope with their difficulties themselves so that they will not be led to expect that somebody else will do it for them.

The report recommends encouragement of juvenile-aid police services, given by specially trained officers. It also urges advanced special training for all professional workers dealing with juvenile delinquency.

Among other measures for delinquency prevention recommended in the report are: family or children's allowances; family-life education for parents and children, and psychological help for estranged parents; vocational guidance for adolescents; efforts to improve school attendance and to prevent employment of children during school hours.

The next United Nations Congress on Crime and Delinquency will be held in 1960. —*Philip G. Green*

Adoption

More than 1 out of every 3 of the 548 children placed for adoption last year by the Children's Home Society of California were children for whom homes were not readily available. One-tenth of those placed had physical handicaps or presented serious medical problems; 2 were blind and 2 totally deaf. One-fourth were of Mexican parentage or other minority groups.

The Society, a privately supported adoption agency now in its 64th year of operation, serves all of California through offices in nine cities in various parts of the State.

On the ground that the need for adoption services requires the joint efforts of public and private agencies, the Society has long championed public adoption programs. It supported the legislation that authorized establishment of county adoption agencies in 1947 and since then has helped various counties establish services.

Child Labor

Registration of Ceylonese house servants under 14 years of age as a step toward enabling them to get some education was urged by the senior delegate from Ceylon at a joint meeting early this year of the International Federation of University Women and the Pan-Pacific Women's Association, held in Manila, Philippine Islands.

The delegate said that 38,000 children in Ceylon are working as servants on plantations, losing all touch with their homes and lacking opportunity for any schooling. The fact that these young boys and girls receive food, clothing, and shelter blinds their parents, she said, to the virtual loss of their children, and to the seriousness of their education lack. Twenty-five thousand additional children under 14 are working in other occupations, she reported, and urged that employers and parents share responsibility for observance of the school-attendance law.

The delegates from other Asiatic countries revealed a similar concern for children in employment, but some expressed the feeling that domestic employment was currently the only advancement open to children of the villages and that therefore the avenue for improvement had to be through employers. The conference exhibited special concern for efforts to reduce illiteracy, by establishing educational facilities for all children.

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A large proportion of the more than 4,300 children under 16 that were found employed on farms during school hours in the fiscal year 1954, were below normal in educational attainment, according to the U. S. Department of Labor.

Records for 4,023 of the children old enough to have completed at least one school grade showed that 48 percent had not completed grades considered normal for their age by the U. S. Office of Education. One hundred and nineteen children had never attended school at all; 12 had entered the first grade but had never completed it.

Six percent of the children employed were under 8 years of age.

Crippled Children

Four interregional meetings on services to crippled children, called by the Children's Bureau late in September and early October, brought together administrators and other professional personnel from the States and Territories to consider ways in which these services might be further developed. Before adjournment late in July Congress appropriated for the first time the full $15,000,000 authorized under the Social Security Act as the Federal share in this program, thus increasing by more than $4,000,000 the money available to the States for crippled children's services.

Held in Denver, Chicago, Washington, D. C., and New York, the conferences focused largely on ways and means of developing services for children with specific types of handicaps—epilepsy, cardiac conditions, speech and hearing disorders, congenital deformities, mental retardation—although types of services important for all crippled children, such as nutrition and dental care, and services for specific groups of children, such as migrants and Indians, also received attention.

Speakers and panels at the meetings gave the conferees technical information on recent developments in knowledge and treatment of the conditions under discussion, and told of ways in which the various States were attempting to apply this knowledge to the children needing attention, thus revealing how geographical, economic, and other differences among the States bring individual problems to each.

Some differences in viewpoint also came into discussion—for example, whether or not the term epilepsy, which is not a disease but only an admission that the cause of seizures is unknown, should continue in use. There was, however, general agreement among the experts that an effective program of seizure control must involve three important aspects: early case finding, early treatment, and careful followup. States with such programs, it was revealed, have found children subject to seizures to be much more numerous than generally suspected.

Different viewpoints also emerged on the extent to which a State program could become involved in the free dispensing of drugs even for conditions, such as rheumatic fever or convulsive seizures, in which medicines play the central role in treatment and control. Some States have found it possible to apply a liberal interpretation of the term "medically indigent" in the provision of drugs for such conditions, while others more generally require the patient's family to pay for medicines, not only on the theory that parents should accept as much of the responsibility for the child's health as possible, but also to protect the limited funds available for the program.

Two of the conferences presented sessions on amputees focused on the Michigan program which has been cooperating with the National Research Council in the development of improved prosthetic appliances for children with congenital or traumatic amputations. The speakers emphasized the importance of frequent, periodic followup of such children and careful work with parents to help them understand the potentialities of the prosthesis.

No matter what the affliction under focus, the team concept, especially as developed in a program for children with cleft lip and palate, received major emphasis in descriptions of what might be done and is being done in some States. There was also a great deal of emphasis on the preschool period as the focus of case-finding efforts—as a time when children are most amenable to treatment, but least likely to come to attention of persons outside the home.

Care of Prematures

Five institutes in the care of premature infants are being offered for 1955–56 by the New York Hospital-Cornell Medical Center in the seventh year of a training project sponsored by the State Department of Health and the Children's Bureau, U. S. Department of Health, Education, and Welfare. They are designed for physicians and nurses in charge of hospital premature nurseries and special centers and for medical and nursing directors and consultants in State and local premature programs. The first of the series of 2-week (for doctors) and 4-week (for nurses) institutes got underway in late September. Others will take place in November, February, April, and May, if advance registration warrants them. No tuition is charged and stipends are provided to cover expenses. Further information may be obtained from Institute in the Care of Premature Infants, Box 143, the New York Hospital, 525 East 68th Street, New York 21.

Migrants

More than 100 migrant families following the crops from Florida to Virginia and New York this past summer and fall were accompanied by an observer assigned by Florida's Bureau of Maternal and Child Health to identify and report on the families' health problems.

This step is part of a 3-year demonstration project on the health of migrants which is assisted by a grant from the Children's Bureau and is under the direction of a sociologist employed by the Florida Board of Health. The information gathered is to be used in planning both a State and a national program of providing continuity in health services for migrant workers and their families, as recommended at the May 1954 East Coast Migrant Conference at Washington.

During the months before leaving the home base in Palm Beach County, Fla., each family member available was given a physical examination by county health department or local physicians. Adults were given blood tests and chest X-rays, and children received immunizations. Persons with physical defects were referred to local agencies for correction before the start of the migration. Socioeconomic data were also collected from the families.

The medical record for each family was entered on a large folder, which was presented to the family before its departure. Duplicates were kept at the project's central office in Florida. The purpose of the record folder was to give information about previous services to any health workers who might provide immunizations or other medical services to the family members during the migration, so that the patients could be helped more intelligently.

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Last summer Idaho's and Oregon's departments of health cooperated with the Public Health Service, the Children's Bureau, and the Office of Vocational Rehabilitation in carrying out a health project for more than 4,000 migratory agricultural workers and their families in several counties in the Lower Snake Valley that do not have organized local services.

The migrants arrive in Idaho about May 1 each year, and remain into November, housed in labor camps. The project sent a mobile clinic from camp to camp, giving physical examinations; blood and urine tests; immunizations against smallpox, typhoid, diphtheria, tetanus, and pertussis; and other health services. The personnel arranged for treatment when necessary, seeking the help of local physicians, and for hospital delivery of pregnant women.

Since most of the migrants are Spanish-speaking, an interpreter accompanied the mobile clinic.

. . .

Colorado's Department of Health participated in two major projects for migrants this past season with the help of Children's Bureau funds—one at Fort Lupton in Weld County in the heart of the sugar-beet country and one in peach-growing Mesa County. The Fort Lupton project this year centered around a clinic staffed by the County Medical Society, which provided both medical examination and treatment for children and adults, in addition to the immunizations and screening for communicable disease with which the project was largely concerned last year.

The Mesa County project, which centered around increased public-health nursing and improvement of local interdisciplinary relationships and communities, was run locally with the help of State and Federal funds. Medical and dental services were available on referral and every effort was made to see that the migrants used them.

Among the first visitors at the Fort Lupton clinic were 27 Spanish-American children brought in for health examinations by school bus from Wiggins in nearby Morgan County. Children of migrant farm workers in Weld, Adams, and Morgan counties who had come up from Texas for the beet season, they were the pupils of a special summer school for migrants operated by the Wiggins School District with the assistance of the Colorado State Department of Education. The children were receiving free milk at school and, when necessary, free lunches, provided through the school-lunch program.

. . .

An experimental summer school for migrant children 5 to 12 years old was operated for a month and a half last summer in Potter County, Pa., by the Department of Education, Pennsylvania State University, in cooperation with the University's Christian Association. Funds for the project came from the National Child Labor Committee through a grant from the Philip Murray Foundation. The project was located in the town of Ulysses and was coordinated with a number of other projects for migrants in the county, including a day-care program sponsored by the Pennsylvania Department of Welfare and a health program offering immunizations and physical examinations operated by the State Department of Health.

The purpose of the school was to find how migrating life had affected the children and how supplementary educational experience might improve their lives. Since there were 11 teachers for 43 pupils, the children received a high degree of individual attention. Tests given at the beginning and end of the school session showed that, while some of the children had improved academically, the most noticeable improvement was in nonacademic skills such as social adjustment.

In addition to the classroom work the project also included visits to the children's parents in the camp, an open house for the community, and a recreation program operated jointly with the Society of Friends.

Among the public and private groups represented on the school's advisory committee were the State Departments of Labor and Industry, of Public Instruction, and of Health; the local public schools; the National Child Labor Committee; the Pennsylvania Citizens Committee on Migrant Labor; the American Friends Service Committee; and the Philadelphia Yearly Meeting of Friends.

. . .

Maryland's State Health Department this year for the first time organized a statewide program to provide selected health services to migrant laborers and their families. In the eastern part of the State, State and county health departments, in cooperation with the Public Health Service of the U. S. Department of Health, Education, and Welfare, gave a physical inspection, including a blood test for syphilis, to each of more than 4,300 migrants, about 300 of whom were children under 12 years of age. Without waiting for the test results, the health workers offered to give all persons over 12 an injection of a penicillin preparation. Those found positive received followup examination and treatment. Children of mothers who had been treated previously for syphilis were also tested and treated.

The services were given without charge at clinics set up at farms, factories, plants, and other places where migrants were concentrated.

Persons with health problems other than syphilis were referred to State health department physicians.

In other areas of the State over 500 migrants were given a blood test for syphilis. Those found positive were examined by the county health department and treated if necessary.

Child Development

Since 1950, when the Institute for Psychoanalysis, Chicago, began its pilot project to disseminate psychoanalytic principles of child care and education to nonmedical professional workers for children, 97 such workers have participated. Fifty-one are social workers, 21 teachers, 18 psychologists, 4 nurses, and 3 ministers. Almost all have a master's degree; some have a Ph. D. and others are working toward it.

The 3-year evening program aims to arrive at and teach a common body of knowledge basic to all fields concerning children, and to help the various types of workers make this knowledge an integral part of their own disciplines. The faculty offers not only group instruction but also individual supervision of direct work with children in a wide range of agencies, institutions, and schools in the Chicago area.

The project has a twofold purpose: to contribute to the development of better methods of helping the emotionally disturbed child and through research to learn more about the processes that facilitate normal emotional development and how to prevent interference with that development.

Continued support from the Field Foundation has made the project possible; the Moorman Foundation, the Wieboldt Foundation, and the Public Health Service of the U. S. Department of Health, Education, and Welfare have also contributed.

For Amputees

The Midwestern Area Juvenile Amputee Center specializing in the care of children who have lost arms or legs is now in operation at the Mary Free Bed Children's Hospital and Orthopedic Center in Grand Rapids, Mich. Federal funds totaling $55,000, allocated by the Children's Bureau to the Michigan Crippled Children's Commission for the establishment of the center, are to be used primarily for provision of the highly skilled service necessary for diagnosis, treatment, and training in the use of prosthetic devices to child amputees from birth through 20 years of age and the extension of specialized educational opportunities to persons working with child amputees in other areas of the country.

For many years the Michigan Crippled Children Commission has carried on a program at the center for child amputees within the State of Michigan. It will now extend this service to children from the other States. The potential area to be served by this center has not yet been determined but it will be immediately available to children from Illinois, Indiana, Michigan, Ohio, Wisconsin, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota. The Michigan Crippled Children Commission will be the liaison between the hospital and the official crippled children's agency of the State where the child lives.

Mental Retardation

A program for mentally retarded children, including diagnosis, parental guidance, coordination of community resources, community education, training of professional workers, and clinical research, has been begun by Washington's State Department of Health as a part of its crippled children's services. The program, which is expected to extend throughout the State eventually, has been begun with a center established as a "primary unit," at the University of Washington School of Medicine. The unit offers complete services to diagnose and evaluate children suspected of being mentally retarded. It is developing a teaching aspect to give medical students and pediatric residents fundamental training regarding mental retardation.

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The National Association for Retarded Children, an organization of parents and friends of the mentally handicapped, reports that it now has affiliates from 47 States as compared to 9 States in 1950. Its membership includes over 100,000 individuals and families. . . . The Hamilton County (Ohio) Council for Retarded Children is urging State legislation requiring physicians to report all cases of mental deficiency to local boards of health.

Nutrition Services

Child-caring institutions and foster-family homes in more than two-thirds of the States receive service from public-health nutritionists or dietary consultants, according to a survey made by a graduate student in public-health nutrition at the University of Michigan.

Thirty-five States replied on questionnaires that their public-health workers provide this type of service, usually in cooperation with the State department of welfare.

Evaluation of menus is the most common activity—carried out in 27 States. Food service is surveyed in 21 States. Nutrition education programs are provided for various groups: for social workers (20 States), for directors of child-caring institutions (19 States), for foster mothers (15 States). Other

services given include establishing nutrition standards for licensing, training public-health personnel in applying these standards, and training food-service workers.

Safety and Accidents

An accident-prevention service to school-bus fleets, now available from the National Safety Council, provides to those in charge of bus operations the safety-training materials developed by the Council's motor-transportation division. These include awards to safe drivers, newsletters, posters, brochures, and monthly letters to be mailed to drivers.

West Virginia's schools, after trying the program during a 4-year period, found that in 1952 bus accidents were fewer by 16 percent than in the year before the program started, although motor-vehicle accidents in the State as a whole had increased 12 percent. During 1952 the State operated 20 percent more school buses than in 1948; the buses transported 14 percent more pupils and traveled 18 percent more miles.

. . .

Accidents took the lives of 17,121 children 1–19 years of age in the United States in 1952, the latest year for which figures are available. Mortality due to accidents was highest in the group 15–19 years of age—57.1 per 100,000 children in that group. Children 1–4 years of age experienced 37.2 fatal accidents per 100,000. Among children 5–14 years deaths from accidents were somewhat fewer than in the other age groups—22.4 deaths per 100,000 children. In each of the age groups accidents were the chief cause of death.

Homemaker Service

One hundred and fourteen community agencies in 29 States and Puerto Rico are providing homemakers to families who need their help in keeping the home together, according to data compiled by the Children's Bureau and the National Committee on Homemaker Service. Of these, 94 are voluntary and 20 are public agencies.

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Guides and Reports

AN INSTITUTIONAL APPROACH TO THE PARENT-CHILD RELATIONSHIP. Milton Willner. Child Welfare League of America, Inc., 345 East 46th Street, New York 17, N. Y. 1955. 11 pp. 50 cents.

Awarded first prize for 1954 by the Mary E. Boretz Award Committee, this paper shows how an agency approached the problem of using the institutional setting to facilitate casework services to the parents of troubled children. When the parent was able to carry even a fractional part of his parental role, both he and his child found more satisfaction in the parent-child relationship.

ART AND PLAY THERAPY. Emery I. Gondor. Doubleday & Co., Garden City, N. Y., 1954. 61 pp. 95 cents.

Shows how play situations and art materials provide a medium of communication between the therapist and the child which may make it easier for the child to reveal his difficulties.

PSYCHOANALYTIC PRINCIPLES IN CASEWORK WITH CHILDREN. Selma H. Fraiberg. Family Service Association of America, 192 Lexington Avenue, New York 16, N. Y. 1955. 54 pp. 85 cents.

Three articles, reprinted from social-work periodicals, describe efforts to solve some difficult problems in children's lives through casework.

ADMINISTRATION, SUPERVISION, AND CONSULTATION; papers from the 1954 Social Welfare Forum, National Conference of Social Work. Family Service Association of America, 192 Lexington Avenue, New York 16, N. Y. 1955. 114 pp. $1.50.

Offers divergent opinions on "three subjects which frequently are viewed in isolation from each other but which actually are closely related."

NUTRITION PRACTICES; a guide for public health administrators. American Public Health Association, Inc., 1790 Broadway, New York 19, N. Y. 1955. 72 pp. $1 a copy; 75 cents each in quantities of 25 or more.

Planned to assist administrators of public-health departments in initiating, conducting, and evaluating nutrition services, this guide stresses the responsibility of the public-health administrator to see that the total community nutrition services are adequate and effective in meeting the existing need.

CASE RECORDS FOR STUDY AND TEACHING. Family Service Association of America, 192 Lexington Avenue, New York 16, N. Y. 1954. 144 pp. Processed. $2.85. Separate units, 40 cents each. Discount on quantity orders of the book or its units.

Eighteen case records, contributed by public and private social-work agencies, are assembled in this collection, planned for use in the classroom and in agency programs for staff development.

SIGNS OF THE HEALTH TIMES—seen at 1955 National Health Forum on forecasting America's health. National Health Council, 1790 Broadway, New York 19, N. Y. 1955. 64 pp. $1.

Takes up a number of factors in planning health programs. Among them are: economic trends and their probable effects on health efforts; atomic developments in relation to health; new miracles to expect from medical science and how social science can help us benefit from them; the role of mass-communications media in health betterment; fluoridation; chronic illness; the Hoover Commission's health recommendations.

WORKSHOP IN THE EDUCATION OF THE EXCEPTIONAL CHILD. Arizona State College at Tempe. 1955. 275 pp. Processed. $2 plus 25 cents for mailing and handling.

Reports a 5-week workshop on exceptional children, which included sections not only on the emotionally maladjusted, the gifted, those with hearing and speech difficulties, the mentally retarded, the orthopedically handicapped, and those with reading disabilities, but also on non-English-speaking children, who are numerous in Arizona.

IN THE JOURNALS

Cross-cultural research

Items, published quarterly by the Social Science Research Council, summarizes in its September 1955 issue a 3-day conference on cross-cultural research on personality development held in Kansas City, Mo., last spring. Anthropologists, psychologists, and sociologists from 13 universities took part, along with the members and staff of the Council's committee on personality development. This committee is continuing the work of the former subcommittee on child development of the committee on social behavior.

The participants repeatedly expressed the need for a general theoretical model comprehending the relationships of society, culture, and developing personality. One suggested step toward this objective, to which the conference itself was regarded as a contribution, was the planning of limited studies, whether by anthropologists, sociologists, or psychologists, with joint attention to such problems as the relation of social structure to socialization.

The conference emphasized the increasing necessity for specialists in the sciences concerned with personality development to share one another's theoretical perspectives, even with regard to research techniques.

The bomb and genetics

The July–August issue of *The Cancer Bulletin*, published by the University of Texas contains an unsigned article on the genetic effects of the atomic bomb. This finds reassuring the results obtained so far by the Atomic Bomb Casualty Commission from the survivors of Hiroshima and Nagasaki in that no significant increase in abnormalities has been found in the first generation. Cooperative study by Japanese and American scientists will need to continue for many years, however, the article says, before conclusive results are available.

Results of a 1952 study are summarized, which "although not conclusive, demonstrate that a fetus in utero may receive sufficient radiation from an atomic-bomb explosion to produce defects of the central nervous system if the mother is within approximately 1,200 meters of the explosion and is not well shielded."

When children can't sleep

Disturbances of sleep in children are the first reliable signs of emotional conflicts, maintains Melitta Sperling in the *Psychoanalytic Quarterly* for July 1955. She adds that this symptom precedes any other overt indications of such conflicts. The article includes six clinical examples of sleep disturbances due to severe neurotic or psychotic disorders. Commenting on the child's actions in one of these cases, the author suggests that this kind of disturbed behavior should not be confused with the actions of a healthy child who, in a desire to participate in the activities of adults, will invent all kinds of devices to postpone going to bed.

Child health in 3 countries

Advances in various fields concerned with child health in Great Britain, Canada, and the United States are described as part of a report on 1954 developments in public health in those countries in the July 1955 issue of *Good Health*, a quarterly issued by South Australia's Department of Public Health. Improvements in maternal and child health, child health, care of handicapped children, mental hygiene in childhood, care of children's teeth, and prevention of accidents, observed at first hand in the various countries, are among the subjects reported on by the author, A. R. Smallwood, M. D., Director-General of Public Health, South Australia. Regarding advances in community health, Dr. Smallwood says, "Health training of children remains the most hopeful venture."

A blind boy learns

How a 3-year-old blind boy, whose widowed mother was employed, slowly learned to get along in a day nursery with 11 sighted children is told by the nursery-mother in the *Kansas Preschool Association Bulletin*, Winter 1955. ("Corky Comes to the Nursery," by Mrs. Royal Mayhan.) By the end of 5 months Corky had given up throwing tantrums, and had improved in many other ways, though he was still retarded in speech.

To express a truth

Psychiatry, above all other branches of medicine, requires a skill in communication, says the *Bulletin of the Menninger Clinic* for September 1955 in an article written by the late Harry Colburn, who before his death was responsible for giving training in writing to resident physicians at the Menninger School of Psychiatry. Noting that great truths, if poorly expressed, often fail to carry the conviction to which they are entitled, the article describes the efforts made at the School "to enable future psychiatrists to write competently for medical journals and clearly for local newspapers and for the private practitioner."

Ocular motor defects

Motor eye defects, extremely common in cerebral-palsied infants, are often unrecognized for 1 to 3 years, says George P. Guibor, M. D., in the *Journal of Pediatrics* for September 1955. Early treatment of these defects, the author notes, is often needed to prevent loss of vision in a deviating eye or to improve general motor ability, especially in patients with the types of cerebral palsy called athetosis and ataxia. The author suggests simple tests to enable physicians to discover an ocular motor defect or subnormal vision in a child, so that children with such defects can be referred to an eye doctor interested in children's eye diseases and their associated motor anomalies.

Petroleum poisoning

One of the commonest types of poisoning among young children is caused by petroleum products, chiefly kerosene, writes Hugh A. Carithers, M. D., in the *Journal of the American Medical Association*, September 10, 1955. In the United States one-fourth of all deaths of children under 5 from accidental poisoning are due to this cause, and large numbers of children become very ill from it. Noting that most kerosene poisonings take place in the South, the author states that in 1953 over 500 Florida children under 6 were treated, 229 of them as inpatients, for this type of poisoning. At least 5 died.

READERS' EXCHANGE

RIDENOUR: ***"In there pitching"***

Dr. Ridenour and I have been fighting the battle of mental-health education for a good many years and I am glad to find her still in there pitching. (See "The Critics and Parent Education," by Nina Ridenour, CHILDREN, September–October 1955.) She brings vast experience, great knowledge, and deep integrity to this field.

I agree with Dr. Ridenour that there are all too many destructive, negative critics whose hostility is quite transparent but who, I believe, do no great harm. Headline seekers and feature writers are almost expected to distort; after all, they must make news and nothing is less newsworthy than calmly considered discussions of educational matters.

I am often more concerned about the friends of mental health than with our critics, even the hostile ones. I am certain that Dr. Ridenour would agree with me in my antipathy to the too easy promises of some Utopia ahead, of the great amelioration of a whole array of human ills and concerns, all as a result of this magic, mental hygiene. One finds much too much of that sort of thing and, unfortunately, it is often perpetrated by those who should know better.

I share Dr. Ridenour's conviction that evaluation is very difficult and that we still lack adequate criteria and techniques for undertaking it. I do not believe we can wait forever to establish ultimate truths. But I have always felt, and still do, that the field of parent education, as do other parts of the larger area of mental-health education, clings stubbornly to unproven and unprovable (and often wishful) shibboleths; and that we who work in this field are still loath to undertake the hard and often unrewarding task of scrutiny and self-examination.

I am not yet persuaded that either the opinions of authorities or the criterion of popularity, alone or combined, provide a method of evaluation on which one can rely. This is no quest for "scientific" proof, and my objection is not at all that these criteria are "unscientific." I simply believe that the facts demonstrating their validity are as yet not forthcoming, and that we need ever greater efforts at careful evaluation of the efficiency of what we are teaching. In this I am obviously in entire agreement with Dr. Ridenour's plea that "The important job is to assess . . .".

Sol W. Ginsburg, M. D.
New York

WOLINS: ***Experiments in methodology***

I have read with interest Martin Wolins' letter commenting on the research contributions of Community Research Associates. ("Robinson: Data-sharing needed," in "Readers' Exchange," CHILDREN, September–October 1955.)

I am sorry Mr. Wolins does not approve of our publication policy. "Community Planning for Human Services" was designed for a general audience, few of whom have special interest in statistical techniques. It is a comprehensive treatise, which includes materials from many sources besides the St. Paul study.

Reports of the three subsequent studies were directed to the communities in which our projects were to be conducted. Each contains an explanation of the statistical approach and basic tables with data derived therefrom. These reports are available to any one interested, and we have reprinted two of them. Miss Robinson's article was based on their materials.

Essentially these projects are experiments in administrative and operational methodology. Procedures are changing continually in the light of experience. We feel it is a disservice to distribute generally descriptions of working processes before tests of practicality and utility have been completed. The Family Classification Project also is at a midway point; our present expectation is that findings from it will be published in book form.

Bradley Buell
Community Research Associates,
New York

RICHMOND: ***Example from California***

In his article, "Medical Education in Transition," Dr. Julius Richmond has presented an excellent review of some of recent changes in medical education. (CHILDREN, September–October 1955.)

It should, however, be emphasized that there is considerable debate as to the value of some of these changes. The medical students' curriculum is now so full that for every new subject matter introduced something has to be eliminated from the curriculum. What scientific information can you safely eliminate?

For many years medical educators adhered to the concept that the medical-school graduate could learn all he needed to know about the sociological, cultural, and psychological aspects of patient care as he practiced. I believe that by and large this concept was valid in a limited way as long as our society was more rural and less mobile than it is today. When one doctor stayed in one community with the same patients for 20 to 30 years he learned a great deal about these people and this community that aided him in the comprehensive care of his patients. Such situations are much less common in our modern society. It is in recognition of major changes in society and in the practice of medicine with its trend toward specialization that many medical schools have introduced special courses integrating the sociological, cultural, and psychological aspects of patient care with the physical care.

At our school we feel that it has been very advantageous for our family medicine program to start the first year the student is in medical school. At this time the average medical student is greatly interested in the patient as a person, partly because he knows so little about organic disease. We believe we can encourage and develop this interest during the first 2 years of medical school to the point that the student continues in this direction on his own during his clinical years and in his hospital training period. Although we do work with the students during their

last 2 years of medical training in their 4-year followup of their family medicine cases, we concentrate our efforts largely on the first 2 years. We also feel that limited clinical experience at this time stimulates the student's interest in his basic-science subjects and in medicine in general rather than detracts from his accumulation of scientific knowledge.

Arthur H. Parmelee, Jr., M. D.
Assistant Professor of Pediatrics, School of Medicine, University of California, Los Angeles

A crowded curriculum

Dr. Richmond's article on medical education is an excellent résumé of various aspects of the situation.

In my opinion, there is a trend toward crowding the curriculum at the expense of scientific experience and of time for reflection; toward didactic, required courses at the expense of elective work in the laboratory. One simply cannot cover systematically every aspect of medicine; indeed it is not desirable so to do.

The great advances in medicine have been attributable in large measure to scientific discoveries; the various psychological and social aspects of medical practice, often not expressed in modern terminology, have been empirically practiced for generations by the great clinicians. The compassionate physician is born rather than taught.

Dr. Richmond says "undergraduate medical education is not terminal education of the physician." Is it not for the great majority of doctors so far as vital experience with the exact sciences of the laboratory are concerned?

I believe experience in a research project at the undergraduate level is of potentially greater pedogogical importance at that stage than learning how to deal expertly with patients and families; and how to appraise accurately and sympathetically community and personal situations. One reason research is so important is that only in the formal setting of medical education is opportunity for exact and supervised observation and study of a special problem available to most students. In contrast, experiences with various social and psychological processes are bound to come sooner or later to every physician. I do not intend to emphasize relative importance but rather, sequence, availability, and opportunity.

In his article Dr. Richmond includes an important paragraph on the role of example in effective teaching of comprehensive care for patients. It is true, as he points out, that the medical-school framework for such teaching is somewhat idealized because facilities available to medical schools are not always available in other communities. But what is done in one community is stimulating to performance and accomplishment in those less favored. And, of course, one cannot exemplify in teaching less than the best known to the teacher.

I note the absence of the subject of medical history. Teaching of this important aspect of comprehensive medical care must not be neglected; formal courses are desirable but not necessary, if relevant material is adequately integrated in presentation.

Grover F. Powers, M. D.
Professor Emeritus of Pediatrics
Yale University

WITMER: *Anomie and child rearing*

In her presentation of the analysis of Baltimore data undertaken by Bernard Lander, Helen Witmer has clearly described the phenomenon of *anomie* as a possible major source of juvenile delinquency. ("Juvenile Delinquency and *Anomie*," CHILDREN, September–October 1955.)

The idea that "normlessness" in the life's sphere of a youngster is likely to lead him into juvenile delinquency has captured the attention of sociologists for some time. The full values of the concept and of its statistical analysis, however, are by no means established. Dr. Witmer's suggestions for further research on this and for its application to practice merit attention.

The question of whether *anomie* is not also to be found in the more prosperous segments of the population represents a significant research challenge. In recent years the writer has been impressed by a number of signs which suggest that there is in the making a philosophy of child rearing and education which represents dangerous errors in the interpretation of the Freudian discoveries. Apparently, our recognition of the power of an overstrict conscience has led many persons to the assumption that the superego creating forces are suspect by definition and that *they* should be restrained rather than impulses. Research into the relationship between *anomie and* juvenile delinquency may well explore the consequences of this widespread error upon the behavior of parents and teachers and thus of children and youngsters.

Otto Pollak
Department of Sociology, Wharton School of Finance and Commerce, University of Pennsylvania

A word of caution

In her commendable intent to maintain a simple and lucid style of exposition, Dr. Witmer found it necessary to omit reference to the definite, although not extensive, sociological literature on the ecology of juvenile delinquency. It should be noted, therefore, that Lander's study in both its methods and findings is strikingly similar to the two Shaw and McKay Chicago studies of 25 and 12 years ago respectively. The latter in particular, "Juvenile Delinquency and Urban Areas," found also that it is not the externals of the social environment such as housing, income, and the like, but the organization and spirit of social life which represents the relevant correlate of delinquency.

For this reason special emphasis should be given Dr. Witmer's word of caution regarding the dependability even of such sensitive indexes (for Baltimore) of the social life of a community as its racial heterogeneity and proportion of owner-occupied dwellings. In other cities, as for example Chicago, middle-class apartment house districts with low proportions of owner occupancy have low rates of delinquents. Similarly, many of Chicago's racially homogeneous areas have very high rates of delinquents, while on the other hand some of its racially heterogeneous areas have low rates. Hence, regardless of the sensitivity with which particular indexes may reflect the character of a community's social life at particular times and places they can be no more than *post facto* reflections of that social life, never causes.

The reduction of *anomie*, or social disorganization, found in areas of high rates of delinquents should, as Dr. Witmer proposes, remain the object of effort in delinquency-prevention programs, rather than merely the amelioration of its variable symptoms.

Solomon Kobrin
Sociologist, Chicago Area Project and Illinois Institute for Juvenile Research

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five percent discount on quantities of 100 or more.

EDUCATION FOR THE PROFESSIONS. Organized and edited by Lloyd E. Blauch. Department of Health, Education, and Welfare, Office of Education. 1955. 317 pp. Paper, $1.75; buckram, $2.75.

More than 30 professions are described in this report, a number of which directly concern children, including medicine, nursing, dentistry, public health, social work, physical and occupational therapy, home economics, and teaching. The publication reports the development, current problems, and educational status of each and lists schools offering professional study.

COUNSELING AND EMPLOYMENT SERVICE FOR YOUTH. Department of Labor, Bureau of Employment Security. 1954. 70 pp. 30 cents.

Among the subjects covered in this supplement to a more inclusive general handbook, "Counseling and Employment Service for Special Worker Groups," are: placement of beginners in suitable jobs; legal safeguards and labor standards for youth employment; school-employment service relationships; and employment counseling and placement of high-school graduates and drop-outs. An appendix reproduces forms used by various States in their programs for youth leaving school to enter employment.

PREMARITAL HEALTH EXAMINATION LEGISLATION; analysis and compilation of State laws. Department of Health, Education, and Welfare, Public Health Service. PHS Pub. No. 385. 1954. 114 pp. 40 cents.

This publication presents a history and compilation of the laws in the 40 States and 2 Territories that require blood tests and physical examinations for venereal disease.

DIRECTORY OF FULL-TIME LOCAL HEALTH UNITS, 1954. Department of Health, Education, and Welfare, Public Health Service. PHS Pub. 118. Revised 1954. 58 pp. 25 cents.

Revised July 1954, this directory lists, by State, full-time health units serving local areas, together with the name of the health officer of each unit, or other designated administrative head.

JOB GUIDE FOR YOUNG WORKERS; 1955 supplement. Department of Labor, Bureau of Employment Security. 10 pp. 10 cents.

This supplement to a bulletin noted in the November–December 1954 issue of CHILDREN offers job-guide information on five types of clerical-and-sales jobs and two in the mechanics-and-repairmen group.

PUBLIC TRAINING SCHOOLS FOR DELINQUENT CHILDREN; directory, May 1955. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 70 pp. 25 cents.

This directory of training schools, the fourth published by the Children's Bureau, includes information on the 172 training schools under public auspices in the 48 States, the District of Columbia, Hawaii, Puerto Rico, and the Virgin Islands.

PLANNING TYPE A SCHOOL LUNCHES. Department of Agricultural Marketing Service. PA No. 264. 1955. 10 pp. 10 cents.

To help local school-lunch workers plan nutritious and appetizing noonday meals at a price the children can afford, this guide relates the dietary needs of children to the requirements of the basic lunch pattern known as Type A, explains the steps in menu planning, provides sample menus that meet the pattern's requirements, and includes a check list for evaluating menus.

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